IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEW MEXICO

F. MICHAEL HART, Guardian ad Litem for JOSE JARAMILLO, an incapacitated person,

Plaintiff,

vs. CV-11-0267 MCA

CORRECTIONS CORPORATION OF AMERICA, a Foreign Corporation, CIBOLA COUNTY CORRECTIONAL CENTER, WALT WELLS, WARDEN, and RODDIE RUSHING, WARDEN,

Defendants.

TRANSCRIPT OF PROCEEDINGS
DAUBERT HEARINGS
BEFORE THE HONORABLE M. CHRISTINA ARMIJO
CHIEF UNITED STATES DISTRICT JUDGE
FRIDAY, NOVEMBER 22, 2013, 10:08 A.M
ALBUQUERQUE, NEW MEXICO

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Proceedings recorded by mechanical stenography, transcript produced by computer.

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I N D E X

I N D E X (Continued)

DAUBERT HEARINGS

(Court in session at 10:08 a.m.)

CRD CAROL BEVEL: All rise. Hear ye, hear ye, hear ye. The United States District Court for the District of New Mexico is now in session, the Honorable M. Christina Armijo, Chief United States District Judge, presiding.

God save these United States and this Honorable Court.

THE COURT: You may be seated. Good morning, counsel. You may be seated.

Thank you for your patience here. We're starting a couple minutes late, but I always say it depends on which clock we're looking at, because the one here at the computer tells me we're on time, but the one up there says we're a little late. So good morning.

MS. RETTS: Good morning.

THE COURT: All right.

Let me formally call the case of Hart v. Corrections Corporation of America, et al. This is on the Court's Criminal Docket, 11-CV-267.

And if I might, please, have appearances from counsel?

MS. CURTIS: Good morning, Judge. Lisa Curtis for the plaintiff. I'd like to make sure that the Court is aware that Mr. Hart may be coming in during the course of

the hearing. He actually spoke right after me at a seminar.

THE COURT: Is there a seminar this morning?

MS. CURTIS: There is.

THE COURT: Over at the State Bar?

MS. CURTIS: Actually, over at the UNM Continuing Ed, on professionalism. And so I spoke this morning, and he came right after me, and as soon as he's done, he's going to come over.

THE COURT: That's an important topic.

MS. CURTIS: Yes.

THE COURT: All right.

MS. CURTIS: Thank you.

THE COURT: That's fine.

MS. RETTS: Good morning, Your Honor. Christina Retts for the defendants.

THE COURT: How are you this morning?

MS. RETTS: Good. Thank you, Your Honor.

THE COURT: All right. Just give me one moment here.

I'm suffering from some allergies. You'll have to excuse me. And it seems to get worse when I'm in the courtroom. I think I'm slightly allergic to the carpet fibers, so you will hear me sneeze a few times. I apologize for that.

All right. We are here for two hearings that have been noted as Daubert hearings in this case, and I appreciate your working with my CRD for the scheduling of this. I will note that we're here in November. In the last month or so we had an issue with the sequestration, as you know. The courts were closed, and the court-affiliated stakeholders were not able to contribute, so there was a down-side to much of our delay to function here as a court.

I don't know if you knew this. Half the building lost power for a period of about two and a half weeks, including this room here, and so those of us who could were shifted over to the west side of the building, including the Chief's chambers, which had no lights, and it was a perfect storm.

So there were reasons why we couldn't accommodate scheduling requests, but we're back on track here. And we do have some flashlights saved up, too, just in case. Everyone here, Julie and Carol, understand what we went through for a couple of weeks, two and a half weeks. But I appreciate your patience here. All right.

The first motion here is plaintiff's motion, a Daubert motion to exclude the expert testimony of Naushira Pandya, M.D. This is on the Court's docket as Docket Number 126.

And this is the plaintiff's motion, so let me address that to you, Ms. Curtis.

MS. CURTIS: Yes, Your Honor.

THE COURT: And if you need to utilize the technology, just let us know. That's not a problem. Carol can assist you with that.

And if you'd take the podium, we can commence here.

MS. CURTIS: Thank you, Judge. I did ask your deputy, if I needed to use it, and she said to give her the signal.

THE COURT: Yes, absolutely. That why we have it here.

MS. CURTIS: Great. Judge, if I may, I just have a logistical question for you.

THE COURT: Okay.

MS. CURTIS: Obviously, Dr. Pandya is on the telephone line.

THE COURT: Yes.

MS. CURTIS: I would like to know at what stage, and whether the Court would like to question her; if I may question her during my time here at the podium; or how the Court would like to conduct that?

THE COURT: Have you talked to opposing counsel about that, how you want to handle this?

MS. CURTIS: No, we have not spoken about it.
THE COURT: Why don't you confer for a minute on that.
MS. CURTIS: Yes, ma'am.
THE COURT: And I'm going to put the doctor on mute here for just a minute.
(Witness' telephone put on mute.)
THE COURT: How do you pronounce the doctor's name?
MS. CURTIS: I'm guessing, Judge, so I'm a bad person to ask.
MS. RETTS: Dr. Pandya.
THE COURT: Dr. Pandya?
MS. RETTS: Yes.
THE COURT: Okay. All right.
(Witness' telephone taken off mute.)
THE COURT: Dr. Pandya, this is Judge Armijo. Are you on the line?
THE WITNESS: I'm fine, thank you. How are you?
THE COURT: I'm all right. Thank you for your patience here.
THE WITNESS: No problem.
THE COURT: Let me know if you cannot hear -- I'm sure you can hear me because the mike is near the Polycom -- but especially if you can't hear the attorneys

who are over at the podium. All right?

THE WITNESS: Sure. Will do.

THE COURT: All right. Ms. Curtis, how do you wish to proceed here?

MS. CURTIS: Yes, Your Honor. Opposing counsel and I have conferred, and I'm going to make a short argument; followed by some questioning of Dr. Pandya; and then an application of the questions and answers that we've heard during that examination; to a short argument; and then I'll turn it over to opposing counsel.

THE COURT: That sounds pretty good. Let's proceed, then.

MS. CURTIS: Yes, Your Honor.

We have filed a Daubert motion concerning Dr. Pandya for several reasons, Your Honor. The Daubert process is important because in the old days we used to deal with experts just on the fly, during trial, and it was very difficult to have a full examination at that time, without the Court being able to really consider their qualifications and bases for their testimony.

And so the Daubert function of the Court, as gatekeeper, really allows us to go into what would be a lot more detailed than we would be allowed to do at trial.

There are precursor cases that we've cited in our briefing, Graham v. Wyeth and Wilkins v. University of

Houston in particular, that talk about requiring particular field experience. And what I mean by that is that the area that's going to be testified on as an expert is something that not only fits into the case, but into the expertise of this particular witness.

These cases are still relevant. And, in fact, progeny from Daubert show that not everyone who is an expert is necessarily an expert in the area that they wish to testify on. Frankly, we are probably all experts on some level in some area. That doesn't necessarily mean that we can give an expert opinion.

Atlantic Richfield v. Farm Credit Bank, which is a 2000 Tenth Circuit case, talks about the second area that I would like to discuss, which has to do with the evidence being not only relevant, but reliable, and that the reliability is the most important function of both the qualification aspect of an expert's testimony, but also the bases.

Because, again, out in the real world, not trial, everyone has an opinion.

But in order for an expert to testify under 702, they've got to have a reliable basis, which is literally the foundation for every piece of evidence that comes before a jury. It's the indicia of reliability that is so important.

The question here is, while Dr. Pandya, as a geriatrician -- that was her actual designation, Judge. And I might ask if the Court could turn on the --

THE COURT: Do you want us to swear in Dr. Pandya at this time?

MS. CURTIS: Yes. That would be helpful.

THE COURT: Yes. Doctor, would you please raise your right hand?

THE WITNESS: Yes.

COURTROOM DEPUTY CAROL BEVEL: Do you solemnly swear that your testimony in this matter shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

COURTROOM DEPUTY CAROL BEVEL: Would you please state your name and spell your last name for the record.

THE WITNESS: Naushira Pandya, P-A-N-D-Y-A.

THE COURT: Thank you, Doctor. All right. Ms. Curtis?

MS. CURTIS: Yes. Your Honor, as you can see -- I hope that you can see it.

THE COURT: Carol, I'm not seeing it on my monitor. Wait a minute. Just give us a moment here.

MS. CURTIS: Absolutely.

THE COURT: You may proceed.

MS. CURTIS: Thank you, Your Honor.

As you can see, Your Honor, Dr. Pandya is a geriatrician. She works in the Department of Geriatrics and is the director of the Geriatrics Education Center at an osteopathic medical school in Florida.

As Your Honor will recall, Jose Jaramillo was 52 years old. He does not qualify as an elder that would be seen by a geriatrician. That is not an issue in the case.

And while I'm sure that Dr. Pandya is an expert in that area, it's not applicable for purposes of expert testimony in this case.

THE COURT: Just for my own information, what is the age where someone would be considered a suitable patient for someone trained in geriatrics?

MS. CURTIS: I think rather than -- I'm sure there's an expert sitting on the phone, and I will ask that question, Your Honor.

THE COURT: Doctor, it's not particularly relevant but is there a cut-off, age-wise? Or is it more condition?

THE WITNESS: The answer is that there is generally geriatricians who will see patients who are 65 and older and have officially reached Medicare age. Some geriatricians are starting to see patients who are in their

seventies because many people are fairly healthy until that time.

But geriatricians also see younger patients who have chronic physical limitations or chronic mental illness, because physiologically they are older. They have the same medical problems as that of an older counterpart.

So there's no cut-off. Geriatricians see people with multiple chronic illnesses and physical and psychological problems.

THE COURT: All right. Thank you.

MS. CURTIS: Yes, Your Honor.

So the issue about gerontology, which you have adequately explored, about a typical geriatrician, the age of the patient that they are seeing is someone over the age of 65.

The second issue, and really the most significant issue, is the bases for the testimony that is stated in the report that the Court has, for the opinions that Dr. Pandya says that she is going to give in trial.

The references that are on the back page of Dr. Pandya's report list five references, and I will do more to explore these with Dr. Pandya. But just to give the Court, frankly, and the witness, a heads-up what the issues are, is that the reference number 1, Diabetes Care Supplement,

literally has no data that applies to life expectancy.

The second reference, which is a journal concerning a study that was done on traumatic brain injury, on the second page of that study, as I will discuss with the witness, literally excludes Jose Jaramillo or anyone like him from the study population, such that traumatic brain injury, which is normally what we think of as one of our soldiers coming back from Iraq or Afghanistan following some kind of bomb blast, having a traumatic brain injury, is not a like population.

And as the Court will see and I will speak to the witness about, there is no transferable information such that could be a reliable bases for an opinion.

The third reference is -- it was extremely hard to find because it has no citation attached to it. I have a very dedicated nurse who found a symposium by that name, that contained only an abstract from the study that is listed in reference number 2. So it is the same reference, 2 and 3, except that 3 is only an abstract that was given at a symposium.

Reference number 4 is not a journal. There is no such journal called Neurohabel 2010. The author, Strauss -- there is a Neurorehab, and to the extent that we are able to figure this out, there is a Neurorehab Journal.

However, Dr. Strauss contributed two letters to the editor of that journal only, one in 2004 and one in 2010. The Strauss letters to the editor are not peer-reviewed and, for that reason, are not a reliable basis.

A letter to the editor is never a reliable basis for any expert opinion. It doesn't meet the qualifications of Daubert or any of its progeny.

And so there is nothing in 2010, for Dr. Strauss anyway.

The Neurorehab 2004, Number 19, is where we found the Strauss letter to the editor, so I believe that's what it is.

Then the Williams Textbook of Endocrinology does not have a 2010 edition, as is referenced in exhibit -- I'm sorry -- reference number 5. It has a 2011 edition, which we looked, and there are two sections -- and the entire textbook is enormous. There is no particular reference to any section in it as a basis.

But in the 2011 version there are two sections devoted to diabetes, neither of which include any data on life expectancy.

And so because this expert, while the designation that was given to us by the defendants does not say that she is a life expectancy expert, once we got her report,

that appears to be her issue.

She has literally no reliable basis upon which to give any opinion concerning life expectancy.

And so without a reliable basis for the opinion, she must be struck as an expert.

And, Your Honor, with that, I would, if the Court would allow me, I would like to start my examination of Dr. Pandya.

THE COURT: That's fine.

MS. CURTIS: Thank you.

THE COURT: Let me just inquire. Do you wish to make any brief opening remarks, counsel?

MS. RETTS: Your Honor, we had agreed to sort of a process where Ms. Curtis would go first, and then I will follow her.

THE COURT: That's fine.

MS. RETTS: The only thing I might note, that might assist the Court in listening right now, is that Dr. Pandya actually has two opinions. One of the opinions has not been challenged at all, and that is relative to the diabetic care given to Mr. Jaramillo. So that is not at issue at all.

THE COURT: Okay.

MS. RETTS: So just to be clear that it's not requesting to strike her in the entirety. I understand

this to be just the life expectancy.

THE COURT: All right. You may proceed, Ms. Curtis.

MS. CURTIS: Your Honor, I think it's important that we address the issue that opposing counsel just raised. And that is not true. Dr. Pandya has been -- the request is to strike her in her entirety because diabetic care is not at issue.

He was receiving diabetic care in the facility. There is no question as to whether the diabetic care was appropriate or not.

There's also no request for compensation for diabetic care now.

THE COURT: Is that going to factor into any part of your case, then?

MS. CURTIS: No, other than the reality that he was diagnosed with diabetes in the facility in June of 2007.

THE COURT: And that's background information.

MS. CURTIS: Right, which is agreed.

THE COURT: So, Ms. Retts, is this second opinion relevant in any way to your defense?

MS. RETTS: Yes, it is relevant, particularly to some of the systemic issues that the plaintiffs are trying to allege relative to the medical department. As you may

recall, they're trying to introduce post-incident audits, other audits relative to patients who are not Mr. Jaramillo.

It is his medical condition that is at issue in this litigation. The diabetic opinions of Dr. Pandya show that his care was extremely well managed, which also goes to an understanding of the risk factors he possessed for contracting pneumonia.

THE COURT: Okay. So we have a disagreement, then, on this. The Court understands. So let us proceed.

MS. CURTIS: Thank you.

THE COURT: Okay.

MS. CURTIS: Again, Your Honor, just so you know, we're not challenging the diabetic care. We say it's fine. So I would -- I don't know that there is a disagreement, at least with regard to that issue.

NAUSHIRA PANDYA, M.D. (Appearing Telephonically), after having been first duly sworn under oath, was questioned and testified telephonically as follows:

DIRECT EXAMINATION

BY MS. CURTIS:

Q. Dr. Pandya, my name is Lisa Curtis, and I represent the plaintiff in this case.

A. (WITNESS TESTIFYING TELEPHONICALLY) Yes.

Q. I'm going to ask you a few questions.
A. Okay.
Q. Dr. Pandya, could you please explain to us what your regular job is, please?
A. Yes. I am a professor and chair of the Department of Geriatrics, and I also direct the Geriatrics Education Center, which is a federally funded grant to promote geriatrics education, and there are about 45 in the country.

And my job is divided. About 50 percent is clinical practice and 50 percent teaching. And throughout my career, I've taken care of very sick people, both in the outpatient, but largely in the long-term care or nursing home setting, and they have been of various ages, from early twenties to over 100 years old, with this similar problem as this unfortunate gentleman.

So in my -- I am medical director of two nursing homes for myself and my group of three other geriatricians who also provide care for patients. And I see patients in the geriatrics clinic and do a few consults in the local hospital, geriatrics consults.

So my job is divided, probably half and half, among -- between teaching and administration, and the rest of the 50 percent is actual hands-on patient care.
Q. And so, Dr. Pandya, a geriatrician normally treats

elders, correct?
A. Not always. As I clarified, there are some people who are so medically complex, such as this gentleman, who have multiple devices, who are not able to take care of themselves, who are totally dependent on others for care. They are physiologically older. Their chronological age may be one thing, but physiologically they are much older.

So geriatricians are often involved in the care of younger people, as I mentioned earlier, with chronic mental or physical debility. You know, the young patient with the head injury would be a perfect example, and adults or children who have cerebral palsy, who are very debilitated.

So a geriatrician's skills are often called upon to take care of younger patients who have the same needs, debilitative.
Q. Dr. Pandya, I would respectfully object that that is not a responsive answer and is in fact narrative.

MS. CURTIS: And I'll just preserve that objection, Judge.
A. That is also --
Q. No. Excuse me, Dr. Pandya. Just a moment.

THE COURT: Doctor, just respond to the question. All right?

THE WITNESS: Oh, okay.

Q. All right. So the regular job of a geriatrician is to treat patients over the age of 65, correct?

A. Generally speaking.

Q. All right. And the patient population that you normally see is a population over the age of 65, correct?

A. The patient population I see, because of the unique differences of our clinic and nursing home, actually varies. I have patients with cerebral palsy in their twenties, up to elderly patients in their -- over 100 years old. So it varies, depending on their needs.

Q. But your normal patient is over the age of 65, correct?

A. Generally, yes.

Q. All right. And so a younger man -- that is, a person under the age of 65 -- who is seen for treatment, that has sepsis, would normally not see you; they would see an infectious disease physician, correct?

A. They would see me if they were in a nursing home. They would definitely see me.

Q. Doctor, let me try that question one more time just to make sure you heard me. A younger man, under the age of 65, who is being treated for sepsis that caused brain damage, would normally not see you; they would see an infectious disease physician, correct?

A. In the hospital setting -- if I may just clarify the

question? When you say -- you know, because patients get transferred to so many different care settings; you know, to hospitals, to rehabs, to nursing homes, to back to the hospital. So it would depend on what setting you meant.

Q. A young man with sepsis. Let's deal with it this way. If a person, a young man under the age of 65 -- under the age of 65 -- has sepsis, the person that a hospitalist will call in to see that patient is an infectious disease physician, correct?

A. That's correct.

Q. All right.

A. In the hospital, yes, indeed.

Q. And, in fact, a patient that has severe permanent brain damage is going to see, typically, a neurologist rather than a gerontologist, correct?

A. If I can just explain one thing? The gerontologist is usually a scientist or an academic who studies aging; whereas, a geriatrician is somebody who is a trained physician with further subspecialty training in geriatrics, who takes care of older adults.

Q. I appreciate the --

A. So the --

Q. I appreciate -- let me restate that question, with that understanding.

A. Yeah.

Q. All right. So you would prefer, as a clinical physician, to be referred to as a geriatrician --
A. That's correct, yes.
Q. -- or a gerontologist?
A. And that is the correct terminology.
Q. All right. Thank you.
THE COURT: Counsel, just excuse me one minute. This is not going to disturb your process. We just need to do something here.
MS. CURTIS: Absolutely.
THE COURT: This is not going to take me off focus, so just go ahead and continue.
MS. CURTIS: Thank you.
Q. (By Ms. Curtis) Doctor, so as a geriatrician, and considering that particular specialty, you recognize that Jose Jaramillo has no geriatrician involved in his care, and never has?
A. May I answer that question?
Q. Yes, please.
A. Okay.
Q. Did you hear it?
A. I think that he was in the nursing home for several occasions, many, and his permanent residence has been in a nursing home. So, of course, I don't know all the physicians who took care of him, but nursing homes are

staffed by physicians who are either primary care physicians who have knowledge or interest in geriatrics, such as family physicians, internists, but they are also staffed by geriatricians.

And, in fact, in 2013 this is actually one of the key sites where geriatricians are employed, either as the medical directors and attending physicians in nursing homes.

But I cannot say, you know, because I don't know the qualifications of the physicians that took care of this gentleman.

Q. Let me ask the question this way, Dr. Pandya: If I were to tell you that every physician that has taken care of Jose Jaramillo in the nursing home has been a primary care physician, not a geriatrician, you would have nothing to dispute that, correct?

A. No. That does happen in many settings. It just depends upon the availability of physicians with expertise and, you know, interest in participating in nursing home care.

Q. I'm not speaking of all the people in the nursing home. I'm just talking about Jose Jaramillo.

A. Okay.

Q. That his care is only from primary care physicians and the consultants that that primary care physician chooses,

none of which have been geriatricians. Are you familiar with that?

A. Yes, I'm familiar with that situation, certainly.

Q. All right. You understand that Jose Jaramillo, at 52 years old, with diabetes and a feeding tube and severe brain damage, cannot be compared to an 80-year-old man with diabetes and a feeding tube, with severe brain damage?

A. If I could qualify that? Mr. Jaramillo, although chronologically is 52 years old, physiologically he is not 52 years old. He has had far more than his share of medical problems and insults than a normal 52-year-old would.

He is not a 52-year-old, in terms of he needs gastrostomy feeding. He cannot do any of his activities of daily living, nor can he do instrumental activities of daily living. He has a colostomy. He has gone into renal failure. He has had sepsis, pneumonia, pressure sores.

He is physiologically much older than a 52-year-old patient.

Q. Dr. Pandya, respectfully, I would have to move to strike that answer. The question I asked you specifically was: A 52-year-old man with diabetes and a feeding tube cannot be compared to an 80-year-old man with diabetes and a feeding tube, correct?

A. Not exactly word-for-word to an 80-year-old. I was just trying to say that he is physiologically much older than a 52-year-old.

Q. You have never seen Mr. Jaramillo, correct?

A. No. I have seen pictures of him in the medical records that I was asked to review.

Q. So you've never examined Mr. Jaramillo?

A. No. But I've read in detail the nursing notes, you know, the therapy notes, describing what he can and cannot do for himself.

Q. I would like to go through a couple of issues just from a factual standpoint, and then we'll go to the references that I talked about a few moments ago.

From a factual standpoint, there is no proof anywhere that Mr. Jaramillo had diabetes one day before June 20, 2007, correct?

A. Let me review my records for a minute. So, yes, there is, because in June, I noticed, when he had an intake screen, he reported he had no disabilities, and he said he didn't have diabetes.

But when his -- a few days later, on June 20, when his blood sugar was checked, it was 547. And he had had a 20-pound weight loss, which he reported. And not only that, his hemoglobin A1c, which reflects the average glucose control, over the past three months was 14 percent,

which is astronomically high.

So he did have diabetes before June 20, 2007, and he probably had it undiagnosed for several years.

And I'm basing this statement on the United Kingdom Prospective Diabetes Study, which was a large study to look and see, did good control matter in people with Type II diabetes. And they looked at a subsection of patients, just to study their physiologic insulin-producing capacity.

And from that, and it's well accepted by every endocrinologist and physician and the literature, they found that in that patient population they studied in detail, at the time of diagnosis, 50 percent of them had complications. At the time of diagnosis, they already had diabetic complications, and they had 50 percent of their pancreatic reserve.

So when you look at that data, when you extrapolate the graph backwards, when did they have 100 percent of their pancreatic function, it went back eight to ten years prior to diagnosis.

So I state Mr. Jaramillo had diabetes several years before he presented.

MS. CURTIS: All right. Again, I must object and move to strike your answer.

Q. The question I asked specifically is: Dr. Pandya,

there is no proof in the record whatsoever that Dr. -- excuse me -- that Mr. Jaramillo had diabetes one day before June 20, 2007?

A. I'm sorry. There is proof, because his hemoglobin A1c was 14 percent. That does not happen overnight. It takes months to develop an A1c of 14 percent.

Q. All right. So --

THE COURT: The objection is overruled, by the way. Counsel, let's proceed.

MS. CURTIS: Yes.

Q. So the best -- the only piece of evidence that you have that Jose had diabetes for any short period of time prior to June 20, 2007, is what his A1c lab found; is that correct?

A. Yes.

Q. All right. You recognize that Mr. Jaramillo is not obese in any way, shape, or form for several years, correct?

A. I have noted that in June 2007 his body mass index was 32 kilograms/m2, which does make him obese.

Q. No, Dr. Pandya. For the last many years, it is clear that Jose Jaramillo is not obese in any way, shape, or form?

THE COURT: Can you be more specific, counsel?

MS. CURTIS: Yes.

Q. From the time of his brain damage -- and let's start with the records, all the records that you reviewed from the nursing home that he's in -- it's clear that for the last four years, at least, that Mr. Jaramillo is not obese, correct?

A. I'm sorry. I don't have any notes of what his body mass index has been recently, so I can't answer that accurately.

Q. All right. So you don't know one way or the other whether Mr. Jaramillo is currently obese?

A. Currently, no, I do not.

Q. Do you recommend -- excuse me. You recognize, as a geriatrician, that no doctor is going to come to you for a consult on a patient like Mr. Jaramillo, who has pneumonia? That would be either an infectious disease doctor or a pulmonologist, correct?

A. No. We treat patients with pneumonia all the time. Not everybody with pneumonia needs to see a specialist. And that varies around the country. But geriatricians treat patients with pneumonia all the time, whether it's, you know, so-called walking pneumonia in the outpatient setting, in the hospital, or in the nursing home.

They do not all need to see a pulmonologist or, you know, an infectious disease physician or so forth.

Q. The question I asked you was: No doctor is going to

come to you for a consult on a patient with pneumonia? If a doctor needed a consult, they would consult either an infectious disease physician or a pulmonologist, correct?

A. Yes. Specifically if this was for pneumonia, yes, that's right. I think I misunderstood and responded that geriatricians, you know, treat patients with pneumonia all the time. So that was my perception.

MS. CURTIS: Object and move to strike the last answer.

THE COURT: Overruled.

Q. Dr. Pandya, no doctor is going to come to you for a consult on the treatment of venous thrombotic disease? That consult would be to a vascular surgeon or a cardiologist, correct?

A. If I may say, respectfully, generally most physicians treat this quite comfortably. They do not consult unless the person had a pulmonary embolism, which actually this gentleman did. But just for, you know, venous thromboembolism, or deep vein thrombosis, most physicians are quite capable of treating that condition without consulting anybody.

Q. Doctor, the question I asked you is: No doctor is going to come to you, as a geriatrician, as a consult to treat venous thrombotic disease; that consult would be to a

vascular surgeon or a cardiologist, correct?
A. No, they wouldn't consult a geriatrician specifically for that, no.
Q. And if a patient has C. diff. infection, cellulitis, osteomyelitis, no doctor is going to consult the geriatrician for those illnesses? Again, those consults would be either to infectious disease or to an orthopedic physician, correct?
MS. RETTS: Your Honor, I would object to the relevance of this line of questioning as to whether another doctor would require a consult of a geriatrician, is not the relevant inquiry. It's, rather, whether the geriatrician would be qualified to actually treat the patient.
Dr. Pandya has answered some of the questions. And in that case, her qualifications and experience and ability to offer testimony in this case, compared to whether some hypothetical doctor for some hypothetical patient might request that she consult on a case, versus whether she is qualified to treat that type of person.
THE COURT: The Court is inclined to agree. Where are you going with this line of questioning? What are you trying to establish?
MS. CURTIS: Yes, Your Honor. The complications that Dr. Pandya has stated in her report that actually

reduce life expectancy, potentially, for diabetic patients are conditions that are typically treated by other specialists, not by a geriatrician. And that was my -- that very much was my point, taking those particular areas that I've just referenced out of Dr. Pandya's report.

THE WITNESS: May I say something?

THE COURT: Well, yes, in just a moment. Then I think you need to focus the question specifically on the statements in her reports that relate to that. I think that the objection has some merit here.

So I'll let you rephrase your question.

And just be responsive to the questions, Doctor. If not, Ms. Retts will, I'm sure, provide you an opportunity to clarify.

THE WITNESS: Of course. Thank you.

THE COURT: All right.

MS. CURTIS: Thank you.

Q. (By Ms. Curtis) Let me see if I can be very specific. As a geriatrician, Dr. Pandya, a traumatic brain injury patient is not a patient that you would normally treat for the complications from their TBI? That would be more commonly treated by a trauma surgeon, a neurologist, or a neurosurgeon, correct?

A. The acute complications from a traumatic brain injury, that is correct, if it was in the very early stages and

acute setting.
Q. Let's talk very specifically about your references, Dr. Pandya.
A. Yes.
Q. Do you recognize -- do you have a copy of your references?
A. Yes, I do.
Q. The list before you?
A. I do.
Q. All right. So the summary of revisions for 2007, Clinical Practice Recommendations, which is a Diabetes Care Supplement from January of 2007 --
A. Yes.
Q. -- that you have cited as reference number 1, you recognize, of course, that nothing in your reference number 1 gives a life expectancy calculation for a diabetic, correct?
A. That is correct. That reference was merely to support my assessment of the diabetes care that this patient received and that it was adequate and within the clinical practice recommendations. That was merely to -- that was the only reason I entered this reference in the report.
MS. CURTIS: Your Honor, I would move to strike the second part of that and ask the Court once again to instruct the witness that Ms. Retts will have an

opportunity to examine her.

The question solely that I asked is whether reference number 1, I said: It does not contain any data concerning life expectancy?

THE COURT: And she acknowledged that that was correct. She explained that that was merely to support her assessment of the diabetes care that this patient received. I'm going to permit that to stand.

But, you know, we're dealing with an expert in an area that's generally unfamiliar to you, to me, and I think that in a circumstance like this, that a medical expert does have a right to be able to explain their responses, and I'm going to permit that leeway.

Ultimately, obviously, you can challenge that if you wish, and ask different questions, different forms of questions. But I think it's reasonable to permit an expert to have the opportunity to explain an answer.

All right. Let's continue.

MS. CURTIS: Yes, Your Honor.

Q. (By Ms. Curtis) Let's talk about reference number 2, which is Mortality Over Four Decades After Traumatic Brain Injury Rehabilitation: A Retrospective Cohort Study. You are familiar with that reference, Dr. Pandya?

A. Yes.

Q. All right. Do you have a copy of the reference?

A. No, I'm afraid I don't have a copy of the reference; just my summary statement and my report. I don't have that.

Q. All right. Let's clear up one thing quickly before I go to the reference, itself. Reference 3 is from a symposium; is that correct?

A. Yes, I believe so. It was from the Federal Interagency Conference.

THE COURT REPORTER: I'm sorry? The Federal Interagency --

THE COURT: Interagency? Is that what you said?

A. It says "Federal Interagency Conference," according to what I found, "On Traumatic Brain Injury."

Q. All right. So all of that reference number 3 is a restatement of the reference at reference 2?

A. Uh-huh.

Q. And it has only an abstract of that study, correct?

A. Yes.

Q. All right. So let's talk about the article under the "Methods" section of reference 2. You recognize that the method that was used for the study is, in fact, and has to be set out in the publication of the study findings, correct?

A. Yes. The methods have to be explained.

Q. Doctor --

THE COURT: Doctor, say that again.

THE WITNESS: I said, the methods do have to be explained, if I understood the question right.

THE COURT: All right.

Q. Yes. And so you recall, of course, that under "Methods," that all the data was from the Craig Hospital in Colorado?

A. Uh-huh.

Q. I'm sorry. You need to answer verbally.

A. Oh. Yes.

Q. Thank you. And that the Craig Hospital specializes exclusively in the treatment of spinal cord injury and traumatic brain injury?

A. That's correct. Well, this was a specialty hospital, yes.

Q. But its treatment is limited to spinal cord injury patients and traumatic brain injury patients only?

A. Yes. But if I may say, after the infection was treated in this patient, he was left with brain injury and debility that will be very similar to a traumatic brain injury patient because of his, you know, vegetative state, his pneumonia, feeding tube, pressure ulcers, infections.

Post-infection, he had the same extensive chronic morbidity.

Q. Dr. Pandya, that was not the finding of the physicians that actually did the study, was it?
A. No. I'm just saying that a traumatic brain injury patient would be very similar to a patient such as Mr. Jaramillo, with severe neurological injury and brain injury, secondary infection.
Q. Well, again, the study authors for this particular study -- actually, I'm just going to put up a copy of the "Methods," which is the second page of the study, so that everybody can follow along with us.

It has to say which patients are excluded from the study, as well, correct?
A. Yes. Yes, that's correct.
Q. And so in this particular study, in fact most of the cases that were excluded were found to be brain injury from a non-traumatic origin. Do you know those patients to have been excluded specifically from this study?
A. Yes, that's correct.
Q. All right. So the study that you're citing as the basis for your opinion specifically excludes people like Jose Jaramillo?
A. Yes. Because at that time, there was actually very little research done on life expectancy with patients with meningitis.

But if I could explain something? Because when I

knew I was going to be questioned, I did a little bit more looking, to see if I had missed something. And is it permissible that I can tell you about a study I found that was specific for pneumococcal meningitis?

MS. CURTIS: Your Honor, I --

THE COURT: I'll permit that, counsel.

A. Okay. So this is just on a quick review yesterday. Actually, I found two studies by author Bohr, B-O-H-R, in Journal of Infection. It's a Danish study. One was in July of 1983.

And they looked at the fatality rates in patients with meningitis. And those with pneumococcal meningitis had the highest fatality rate of 8.7 percent. Those with Haemophilus influenza meningitis had 3.7 percent. And those with meningococcal meningitis was 0.4 percent. And this was -- the people were patients directed specific to an infectious disease ward. But the authors noted that the fatality rate was 17 to 20 percent if they were transferred from other institutions, you know, referred from other parts of the country.

And then in 1985, in the March issue of Journal of Infection, Bohr is the primary author, and he looked at causes or factors associated with fatalities, specifically pneumococcal meningitis. He was looking for prognostic factors, and he reviewed 164 cases.

And what they found was fatality was associated with increased age, and they don't specify what age; concomitant pneumonia; also level of consciousness; transfer from another hospital; female sex; age between 16 to 50; and positive bacterial cultures of the blood or cerebral spinal fluid.

So I did -- I was not able to find this at the time I, you know, did my report, but I thought I should just, you know, be a little bit more inquisitive since this was an important question. So I researched this, and this is what I found.

THE COURT: I'm going to strike the answer. Upon further reflection here, the question asked by the attorney was very specific. It was -- let me just reference it here at 10:55:56.

"QUESTION: And so in this particular study, in fact most of the cases that were excluded were found to be brain injury from a non-traumatic origin. Do you know those patients to have been excluded specifically from this study?

ANSWER: Yes, that's correct.

QUESTION: All right. So the study that you're citing as the basis for your opinion specifically excludes people like Jose Jaramillo?"

And the response was:

"ANSWER: Yes. Because at that time, there was actually very little research done on life expectancy with patients with meningitis."

And I'm going to strike the remainder of her answer after that part. Let's continue.

Q. (By Ms. Curtis) Doctor, you recognize also that the authors of the traumatic brain injury study stated very specifically in their conclusion that these findings need to be considered with caution, given the limitations noted with this type of investigation using a relatively select sample of persons receiving in-patient rehabilitation at a single facility. Correct?

A. Yes, that is correct.

Q. And specifically, the findings from the traumatic brain injury study done by Cynthia Harrison-Felix, Ph.D., exclude Jose Jaramillo?

A. Yes, that is correct.

Q. Reference number 4, Neurohabel 2010, Number 19, Strauss, et al., do you recognize there is no journal called "Neurohabel"?

A. Yes. I think I spelled this wrong. When I was looking back at my notes, I believe I spelled that wrong, yes. Of course it will be Neurorehabilitation.

Q. You recognize that there was no study done in 2010 by

Dr. Strauss in even neurorehabilitation?
A. I would have to verify that. I know I spelled the journal wrong. I would have to verify whether Strauss -- whether this study was published at all in 2010.
Q. Well, in fact --
A. Or if that was my error.
Q. Excuse me. I didn't mean to interrupt you. Were you referring, although it doesn't say in reference number 4, to David Strauss? Do you know?
A. I'm looking at authors. I don't know, and I would need some time to research this.
Q. I only have, under the rules that we're required to follow, the ability to test your opinion based on your bases. And so I've done my best to try to find if there is a Dr. Strauss of any kind that has done anything in neurorehabilitation, and all I can find is two letters to the editor.

Were you referencing letters to the editor as bases for your opinion?
A. Yes, I was.
Q. You recognize that letters to the editor by a physician are not peer-reviewed and do not, in fact, contain study data from the author?
A. Well, in this, there also is David Strauss I was able to find, and they present their actual data in the body of

the letter.
Q. But a letter is not a publication. In the medical field, Dr. Pandya, a letter is not a study that has been accepted for publication by a peer-reviewed journal, correct?
A. Well, a letter with data. Because sometimes investigators have a very small study, and they present it as a letter to the editor with the data, and it usually presents the commentary or counterpoints to another study.
So this particular study by Strauss actually had life expectancy, with age and level of severity of disability. They actually put data into the letter.
Q. But you understand that has not been accepted for publication as a study?
A. No, it's not accepted as a study. Yes. Yes, it is a letter to the editor.
Q. Which is literally the opinion of one person?
A. Yes, although sometimes the letter can be a group of people, such as this letter had several authors in there.
Q. Well, that's interesting you should say that, because both the letters I found list Dr. Robert Shavelle. Do you know that?
A. I'm looking at the -- I know -- I found what I was quoting, and it was -- it has three authors in here.
Q. Well, you and I are looking at something different,

because I have more authors than that. Let me just ask you a specific question.

A. Yes.

Q. Do you know that Dr. -- or Robert Shavelle, Ph.D., has been struck on Daubert motions in this federal court, in our state courts, and in courts all over the country from being able to testify concerning his findings on life expectancy?

THE COURT: Hold on just a minute before you answer the question. Counsel?

MS. RETTS: I object, Your Honor, on the basis that there hasn't been any foundation laid that Dr. Shavelle was actually one of the authors of the letter that Dr. Pandya is referencing, so Dr. Shavelle and him being struck in other cases isn't relevant until a foundation has been laid.

THE COURT: Sustained.

Q. (By Ms. Curtis) All right. I guess the problem that I'm having, Dr. Pandya, and maybe you can help me with this, is I'm guessing what your references are. All right? And so I cannot find a reference that matches reference number 4. Do you have one?

A. Yes. I have found what I was looking at, and it is -- let me just check. It is in Neurorehabilitation. It's Volume 19, Pages 257 to 258. So it's a letter.

Q. Dr. Pandya, you omitted something from that citation, didn't you?
A. I'm sorry?
Q. You omitted something from that citation that you just read to the Judge, didn't you?
A. Well, no. I see the authors here, Strauss, D.J.; Shavelle is an author; DeVivo; Harrison-Felix; Whiteneck. And it is entitled "Life Expectancy After Traumatic Brain Injury."

So this is what I've just found, and I know that this -- I believe this is what I was looking at, but I gave an erroneous -- you know, I didn't cite it properly in my report.

Q. The question I just asked you is that you omitted something from the citation you just read to the Judge about the article, correct?
A. I'm sorry. Could you be explicit? I am --
Q. The actual citation is Neurorehabilitation 19 (2004)?
A. Yes. Uh-huh.
Q. And what you listed for us was 2010, right?
A. Yes, and that was my error.
Q. All right. And this is, again, a letter to the editor, and it has to do with traumatic brain injury?
A. Yes.
Q. And we've already discussed that. The question that I

believe I was trying to address with counsel, that you answered a few moments ago, is that you recognize -- and let me just put it up on the screen -- that Dr. Robert Shavelle was actually on that letter?

A. Yes, I see that. Uh-huh.

Q. So the question I asked earlier, that was objected to by counsel from a foundation standpoint, is: Do you recognize that Robert Shavelle, Ph.D., has been excluded from testifying in this federal court, in our state courts, and in courts all over the country specifically concerning these life expectancy findings?

A. No, I did not know that. I had no idea about that.

Q. Number 5, the Williams Textbook.

THE COURT: And while you're starting your questioning, may I take a look at what you were just referring to, the number 4?

MS. CURTIS: Yes.

THE COURT: Thank you.

MS. CURTIS: Your Honor, if I may approach?

THE COURT: All right. Thank you. Go ahead.

MS. CURTIS: Yes, Your Honor.

Q. (By Ms. Curtis) And then going to Williams Textbook of Endocrinology, that is your fifth reference, the 2010 edition?

A. Yes.

Q. And, in fact, Doctor, there is no 2010 edition of Williams Textbook of Endocrinology, correct? There's a 2011?

A. Yes. I already said it was 2011. And I think I put that because I -- this was an error in just typing that. I verified that. And you are absolutely correct, it's the 2011.

And the purpose of the reference was really to show -- just to support the diabetes care aspect of this patient. Of course, this endocrinology textbook would not, you know, talk about prognosis and brain injury.

Q. Dr. Pandya, the Textbook of Endocrinology is much larger than just the diabetes issues?

A. Yes, of course.

Q. All right. And could you just tell the Court, please, what is endocrinology?

A. Yes. It's the treatment -- both diagnosis, management, and treatment of hormonal disorders. So it can range from pituitary disease; thyroid disease; diabetes; could include pancreatic and adrenal disease; sex hormone function; to ovarian or testicular problems; sexual dysfunction.

So it is a very broad field.

Q. All right. So Chapters 33 and 31 of the 2011 edition are the two sections that address diabetes in that textbook. Do you know this?

A. Yes.
Q. All right. And that there is nothing in either one of the sections, 31 or 33, and the 250 pages or so that that encompasses, that have any data concerning life expectancy, correct?
A. No, that's correct. As I said, this is really to support the care of the diabetes.
Q. You are familiar with the American Diabetes Association, correct?
A. Yes.
Q. And you do recognize that the American Diabetes Association states very specifically that all diabetics should in fact be vaccinated with pneumococcal vaccine?
A. That's correct.
MS. RETTS: Your Honor?
THE COURT: Hold on, Doctor. Yes?
MS. RETTS: I would object to relevance. Dr. Pandya is not offering any testimony on standard of care in vaccination, and this Daubert hearing has absolutely nothing to do with that issue.
THE COURT: Counsel?
MS. CURTIS: Your Honor, Dr. Pandya, in her actual designation, literally has no areas adopted. Her report, which she has testified well outside of, has included new references. She says she is an expert in the

area of geriatrics. I believe that's probably true. She is an expert in the area of endocrinology and is making many, many opinions concerning diabetes and life expectancy.

Your Honor, just by way of proffer, the influenza and pneumococcal immunization in diabetes, by the American Diabetes Association, talks about how effective implementation of immunization can reduce the cost of human suffering and health care expenses in people with diabetes, which is exactly what counsel has stated this witness is going to testify about; and that in fact she is here to testify about life expectancy in diabetics, where this directly deals with immunization reducing not only the cost of suffering for a person like Mr. Jaramillo.

And so for that reason, as well as the health care expenditures in people with diabetes, which is a very important aspect of this case, that if she is going to testify, we should be allowed to bring that part of it in.

THE COURT: All right. I'm going to, Doctor, put you on hold for just a minute so I can confer with the attorneys here. All right?

THE WITNESS: Thank you.

THE COURT: So just stay on the line.

(Witness' telephone put on mute.)

THE COURT: I've got her on mute. Let's talk about specifically your use of this witness, counsel.

MS. RETTS: We have three expert witnesses in this case, Your Honor. Dr. Thomas has been hired to specifically address the issue of pneumococcal vaccination and whether it should have been given in this patient related to a correctional health setting and the standard of care in a correctional health setting.

THE COURT: Understood.

MS. RETTS: Dr. Pandya will only be giving testimony specific to the diabetic care; not the vaccination portion of it, the diabetes only.

THE COURT: How do you isolate that, or do you isolate that, from the overall care to a patient in this condition as Mr. Jaramillo?

MS. RETTS: I believe that it can be isolated because she is looking at specific and tailored opinions relative to the management of his sugars, the management of his diabetes in general, versus preventative care; so a difference between preventative care in a correctional setting and an actual management of the chronic illness in a correctional setting.

THE COURT: So what are you going to ask her, if you have her on the stand, on this topic? What are you

specifically going to elicit from the doctor, given the opportunity?

MS. RETTS: If the treatment of Mr. Jaramillo's chronic condition from a management of the diabetic condition, the sugars, the blood sugar levels, that area was consistent within the standard of care. Dr. Thomas will be addressing the vaccination issue and has looked specifically to that. She did not look at that in connection with her report.

THE COURT: What's she going to say?

MS. RETTS: That it was.

THE COURT: All right. Now, Ms. Curtis?

MS. CURTIS: Yes, Your Honor. I literally have -- first of all, that particular statement that counsel just made, I have no contrary statement. The issue has to do with managing diabetes in a correctional institution very much requires pneumococcal immunization. I mean, you cannot separate those two.

And so for her to give an opinion and say that in fact his diabetes was appropriately managed, I should be able to impeach with the statement that frankly she just gave, and that for a diabetic in any setting. All right?

There is also a separate item, which was my next section, which is the American Diabetes Association statement on management of diabetes in a correctional

setting, that it requires that he be vaccinated as part of his treatment as a diabetic; and very specifically for exactly the reason why he's in the condition he is; and that his chance for mortality or very serious morbidity is so much higher because he's a diabetic.

That's why the CDC says all diabetics need to be vaccinated, because diabetics handle pneumococcal disease differently.

THE COURT: All right. Ms. Retts?

MS. RETTS: Which is exactly why we have a correctional expert in medicine in that specific expertise. I'm having a hard time understanding the fit with the Daubert hearing, if Ms. Curtis wants to cross-examine Dr. Pandya on various subjects that's different than the challenge that she has mounted in this Daubert hearing, which is a very limited challenge, to specifically only the life expectancy.

And we may not even call Dr. Pandya as an expert if she is not challenging the diabetic care and dependent upon the Court's other rulings relative to some issues in dispute, including things like the post-incident audits, medical care of other inmates.

To basically show a systemic, kind of over-reaching allegation of bad care within this facility, we would bring in Dr. Pandya to say that his specific diabetic

condition was managed appropriately, to rebut that kind of bad act evidence that's floating out there.

That may not be necessary, depending upon some of the Court's rulings.

THE COURT: All right. I'm going to hold in abeyance a decision here, in consideration of the objection. I'm going to let the witness answer these questions. I just want to hear it out here.

Let's continue.

(Witness' telephone taken off mute.)

THE COURT: All right. Let us continue. Are you still there, Doctor?

THE WITNESS: Yes, I'm here.

THE COURT: All right.

MS. CURTIS: Thank you.

Q. (By Ms. Curtis) Dr. Pandya, are you a member of the American Diabetes Association?

A. No, I'm not. I have participated, though, in writing a consensus statement for diabetes in older adults. I was invited to do that. And I've participated in some conferences.

Q. All right. Do you review their journal called Diabetes Care?

A. From time to time, because I'm also a board certified endocrinologist.

Q. All right. And I believe your answer a few moments ago was that you recognize that individuals with diabetes are to be vaccinated with the pneumococcal vaccine, according to the CDC?
A. Yes.
Q. And the -- I want to make sure I get this correct -- the Advisory Committee on Immunization Practices, which is a CDC committee? Do you recognize that?
A. Yes.
Q. And that the reason that the -- oh, it's also the American College of Physicians, the American Academy of Pediatrics, the American Academy of Family Physicians believe that vaccinating individuals at high risk, like a diabetic, with pneumococcal disease, is important. Do you recognize that?
A. Yes.
Q. All right.
A. Yes.
Q. And that the effective implementation of immunization like pneumococcal vaccine can reduce the cost of human suffering and health care expenditures in people with diabetes?
A. That's a very broad statement, but I do believe in the fact that pneumococcal vaccine is important, and I practice that.

Q. And that it's an important part of preventative services --
A. Yes.
Q. -- for many chronic diseases such as diabetes?
A. Yes, indeed.
Q. Do you recognize that failure to immunize a person with diabetes with pneumococcal vaccine, should that diabetic end up with invasive pneumococcal disease, they have a much higher likelihood of significant mortality or morbidity?
A. Yes. That would make sense because diabetic patients, especially the poorly controlled, have a compromised immune system.
Q. And I believe there's actually a very specific issue that diabetics generally have appropriate humoral immune responses to vaccination, so vaccination works well for them?
A. Yes. It's always been, you know, debated how well pneumococcal vaccine works. Not 100 percent of people, you know, develop antibodies when they're vaccinated. And older people tend to not develop antibodies as well as younger people. But in general, it is still -- the benefits are thought to outweigh the risks.
Q. All right. Do you recognize that the American Diabetes Association also has a statement for diabetes management in correctional institutions?

A. Yes.
Q. All right. And that it is the opinion of the American Diabetes Association that people with diabetes should receive the same care that meets national standards, and that being incarcerated does not change these standards in any way?
A. Yes, I believe that.
Q. As a person with diabetes, Dr. Pandya, you recognize that it's worse for Jose Jaramillo to be bedridden in a hospital, with severe brain damage, than a person that did not have diabetes?
A. I'm sorry. Could you be specific when you say -- I'm not sure if I got this question.
Q. Sure. And that's perfectly fine. Feel free to ask me to clarify.

One of the issues for diabetics is that it's important for them to be able to exercise, right?
A. Yes.
Q. And you recognize that Mr. Jaramillo cannot do that?
A. Yes, indeed.
Q. Because of his brain damage; is that correct?
A. Yes, indeed.
Q. Do you know what the national life expectancy tables are, that are produced by the federal government, Dr. Pandya?

A. I do not know them extremely well. I have looked specifically into, you know, the literature that looks at life expectancy in people with diabetes, but not the national life expectancy tables.

I have looked in the past at life expectancy in people with diabetes, and from the National Health and Nutrition Survey it's clear that for people with diabetes, it's about eight years shorter, eight to ten, than people without diabetes.

Q. Well, Doctor, you did not reference any of those articles in your report, concerning --

A. No, I did not.

Q. Just a moment. Excuse me.

A. But I did, I wrote that as a comment.

THE COURT: Doctor. Doctor. Just a moment. Just answer the question. Do not interrupt. I'm going to recognize the attorney now.

Q. Doctor, you did not reference any study, in your references or your report, concerning decreased life expectancy of diabetics, correct?

A. That's correct.

Q. Do you know how life expectancy is arrived at by the actuarials that compute life expectancy for the national life expectancy tables?

A. No, I don't have that expertise.

Q. Do you know how the New Mexico statutory life expectancy tables are arrived at?

A. No, I do not.

MS. CURTIS: Your Honor, I have no further questions of this witness. If it would be all right with the Court, I would pass the witness to defense counsel now and ask only that I might have a short rebuttal at the end.

THE COURT: Okay. Just give me one moment here.

(Witness' telephone put on mute.)

THE COURT: I put her on mute. Do you need a break any time here? Do we need a five-minute break?

THE COURT REPORTER: Maybe in half an hour?

THE COURT: All right.

(Witness' telephone taken off mute.)

THE COURT: All right. Let us proceed here. Ms. Retts?

MS. RETTS: Thank you, Your Honor.

The issue of Mr. Jaramillo's diabetes and co-morbidities and the medical implications of those things is something that Dr. Pandya is qualified in, based upon her training, her experience, her vast array of knowledge in this area including multiple peer-reviewed publications, presentations, and work in the area of diabetes, as well as in working with those in a long-term care setting.

Life expectancy is important to two aspects of this case, both the life care plan and the hedonic damages; the life care plan, where it has been projected that Mr. Jaramillo will live to 81 years, and the hedonic damages where we have to look at "but for" the injury, what would Mr. Jaramillo's life have been like if he had not contracted pneumococcal meningitis.

This is important where we bring in life expectancy of diabetics, because his life expectancy would necessarily be reduced regardless if he had been injured at all.

So that's something that the jury should consider. And, in fact, in the jury instructions, the specific instruction indicates that the jury can look at the life expectancy tables but can also consider the health, the habits, and other relevant factors of an individual.

Here, what is particularly important is the health of Mr. Jaramillo.

And Dr. Pandya has expertise and training that will be helpful and important to the jury to hear, for them to assess the health situations he faces today and how those impact him; the complications he is likely to suffer from; and how that can affect his life expectancy.

Dr. Pandya's expertise is better suited than an

actuary because she has actually taken into account the specifics of Mr. Jaramillo, looking at his voluminous medical records, the complications that he has personally experienced, and her experience in treating those types of situations, and how that impacts on life expectancy, how she has seen that manifest itself in the various roles that she has had across her medical career, including multiple appointments as nursing home director, and through her research.

Your Honor, I would like to highlight with Dr. Pandya, through her testimony now, some of her experience.

CROSS-EXAMINATION

BY MS. RETTS:

Q. Dr. Pandya, can you hear me?

A. Yes, I can.

Q. Can you tell us what medical board certifications you hold?

A. Yes. I'm board certified in internal medicine, geriatrics, and endocrinology. And I'm also a certified medical director, certified by the American Medical Directors Association. That is added training. It's not a board certification, just to clarify.

Q. And in your capacity as a geriatrician, have you treated patients similar to Mr. Jaramillo?

A. More than I care to remember.

Q. In your capacity as an endocrinologist, have you treated patients similar to Mr. Jaramillo?
A. Yes, indeed.
Q. Are you licensed in the state of New Mexico?
A. I was. I lived in New Mexico for a year, between 2002 and 2003. But I moved to Florida, so I'm not licensed. I worked in Albuquerque for a year.
Q. And when you worked in Albuquerque, where did you work?
A. I worked at the then-Lovelace Health System, as an internist. And they recognized my expertise in geriatrics, so I soon became sort of a geriatrics clinic. All the older adults were referred to me, and the nursing home practice, which was not all that efficiently managed by the internists, was then assigned to me.

So I coordinated the nursing home care, the care of the patients that, you know, belonged to the Lovelace Health System.

Q. When you worked within the Lovelace Health System, did you treat patients who had similar conditions to Mr. Jaramillo?
A. Yes.

THE COURT: When you say "similar conditions," what are you referring to, counsel? There are a lot of conditions here.

MS. RETTS: I intend to go through those specifically.

THE COURT: All right.

Q. Dr. Pandya, with regard to the specific conditions that Mr. Jaramillo has, have you treated patients who have had a prior course of meningitis?

A. Yes.

Q. Have you treated patients who have had diabetes?

A. Yes, very commonly.

Q. Have you treated patients who have specifically had pneumococcal meningitis?

A. Not in the acute stages, because I think they would usually be in an intensive care unit.

Q. Have you treated patients who have had pneumococcal meningitis after the acute stages of that illness?

A. Yes.

Q. Have you treated patients who have had sepsis?

A. Yes, very frequently.

Q. And in both the acute setting and in the setting following --

A. Yes.

Q. -- any complications from sepsis?

A. Yes, indeed, such as respiratory failure, renal failure, pressure sores, and infections like C. diff., nosocomial infections from the use antibiotics, and of

course --

THE COURT REPORTER: Excuse me. I'm having trouble hearing.

THE COURT: Okay. Hold on just a minute here. I think we've had a failure in the sound system, so I'm going to let you repeat your response, Doctor, because we didn't get this.

THE WITNESS: Yes.

THE COURT: The last thing I have here is that the question was:

"QUESTION: Any complications from sepsis?

ANSWER: Yes, indeed, such as respiratory failure, renal failure, pressure sores, and infections like C. diff."

And beyond that was a little bit unclear, so go ahead and continue your response.

THE WITNESS: Thank you. Yes, I don't think I spoke clearly.

A. And so I have treated patients with complications following sepsis, you know, such as respiratory failure. Now, in fact, one nursing home where I'm the medical director has a chronic ventilator unit with very similar location. And I've treated patients with renal failure following sepsis, electrolyte disturbances, pressure sores, venous thromboembolisms, C. diff. infections, and other

nosocomial infections following the use of strong antibiotics, and of course patients who are completely debilitated and functionally, you know, quadriplegic and cannot move or fend for themselves at all.

Q. Dr. Pandya, you just went through a list of medical maladies. Are these all things that Mr. Jaramillo has suffered from during the course of his treatment, that you saw through the medical records that you've reviewed?

A. Yes. Those are some of the complications he has; and moreover, I believe he had delirium; he had urinary infection; kidney stones; he had a right testicular infection; Ogilvie syndrome, which is significant dilation of the colon, and a massively dilated colon, and he required a colostomy for that.

So, yes, very. So Mr. Jaramillo had some additional complications that I did not mention earlier.

Q. And with respect to those additional complications, do you regularly treat patients, in the course of your clinical practice, that suffer from those complications?

A. Yes. They might not all occur in one patient, but I am familiar with all of these complications and the treatments.

Q. Can you tell us what teaching positions you've held?

A. Yes. I was an assistant professor at the University of Missouri in the Department of Internal Medicine and the

Division of Geriatrics. That was for four years, from 1991 to 1995.

And then after that, I did my fellowship in geriatrics and endocrinology at the University of Michigan. That was from 1995 to 1998. So I was having subspecialty training at that time.

Following that, I was on the geriatrics staff and still practicing and teaching in the geriatrics program at William Beaumont Hospital in Royal Oak, and I was also medical director there for the ambulatory care clinic.

And at Lovelace, following, where I was for a year, I was really practicing. It was not a teaching institution.

And then since September of 2003 I've been at Nova Southeastern University, which is an osteopathic medical school. So I mentioned my role is 50 percent or so practice, and the rest is teaching. And so I teach medical students. I teach internal medicine, family medicine residents in the fields of geriatrics and endocrinology. I direct the geriatrics and endocrinology boards for those students.

We also have a geriatric fellowship program which I helped to develop, so I teach geriatric fellows. And, if I may, those are physicians who have basic training in

internal medicine or family medicine, who wish to become geriatricians. So there is a one-year fellowship training for that, for geriatrics. They are required to do some research.

And then I lecture at many conferences, you know, state, nationally. And recently, I've lectured at two or three international conferences.

Q. With respect to the complications that we discussed earlier that Mr. Jaramillo has suffered from, in your teaching capacities, have you taught students about the treatment of those medical conditions?

A. Yes. I would say most of them. And some of them -- you know, I do take care of patients with these complications. Students may or may not have been on-site with me, you know, when a patient has all of the above. But certainly we not only do lecture training, we provide clinical training, so students rotate with us in the clinic. They come with us to the hospital and the nursing home setting.

Q. Mr. Jaramillo is currently in a nursing home setting, correct?

A. I believe so. I would stand corrected if anything has happened recently to him.

Q. Can you give us a synopsis of your experience in working in nursing home or long-term care facilities?

A. So, if I understand right, you mean a clinical synopsis of what sort of medical problems occur in nursing homes?

Q. Starting first with a synopsis of the places where you have worked.

A. Oh, okay. Many places. When I finished my residency, which was in Phoenix at the County Hospital, where I saw a lot of geriatric patients, I then did exclusively long-term care medicine from 1987 to 1991. For four years, I was attending physician for the Maricopa County long-term care system, so I had over 250 nursing home patients on my panel, and that's all I did, was take care of nursing home patients.

And then after that, when I moved to University of Missouri, in addition to teaching and practicing internal medicine, I practiced geriatrics. We had a very complex nursing home in Kansas City, so I visited patients there.

I was also medical director of the rehab unit and the mental health unit. One of the reasons I mention this is because many patients were older and had what we would term as geriatric issues, you know, propensity for weight loss, electrolyte disturbance, frequent infection, pressure sores.

And then I mentioned when I was at William

Beaumont Hospital in Michigan, I trained geriatric fellows over there, too. They had a very successful fellowship program. And in addition to my hospital consults and clinic work at William Beaumont, I was medical director at West Bloomfield Nursing Home.

So I really have had an extensive experience in the long-term care setting.

And then even in New Mexico, I mentioned that I asked for some of my time to be scheduled in the nursing facility that was affiliated with Lovelace.

And, of course, since I've been in Florida, I was medical director for five years at State Veterans' Nursing Home. And currently, I'm medical director at Covenant Village, which is a continued care community with nursing home, assisted living, and apartments.

And I'm also medical director of a facility called Avante at Boca, which is north of Ft. Lauderdale. That's a very complex place with chronic ventilator units. So these are patients who have actually all the manifestations that have been exhibited, but they're on long-term ventilators with difficulty weaning them off ventilators because they are extremely sick.

So we have one unit that's devoted to those patients, and I and my group, you know, carry a large number of those patients.

Q. In those long-term care and nursing home facilities, have you had the opportunity to personally observe the effects of the types of complications that Mr. Jaramillo has suffered from and how those medical conditions can adversely affect a patient's prognosis?

MS. CURTIS: I'm going to object at this point. The standard for expert testimony is not "can" -- "whether" "can" "might" "may." For an expert to give testimony, it has to be reasonably probable. And so I object to that particular question.

THE COURT: Rephrase your question.

MS. RETTS: Thank you.

Q. (By Ms. Retts) Dr. Pandya, in the course of your nursing home and long-term care work, have you had the opportunity to personally observe patients with the maladies that have been suffered by Mr. Jaramillo and observed how those maladies have affected a patient's prognosis?

A. Yes, I have. And not just observing. I actually provide day-to-day care for these patients. I am the attending physician of record, so I'm not just supervising or, you know, directing the care. I'm actually a hands-on physician.

And I have -- it's really devastating. With every event such as pneumonia, such as a kidney stone, such

as a pressure ulcer, particularly a pressure ulcer, it's really a signal for a very bad prognosis.

But my point is that when an older person or a chronically debilitated person has one of these events, it's harder for them to bounce back to their prior level of function and cognition, so they lose more ground every time these events occur.

So, you know, I've observed people over the years from being, you know, interactive and functional, to becoming completely withdrawn or nonverbal, not able to move, you know, becoming totally bed bound, becoming totally dependent on caregivers for even the most basic things like turning and toileting and bowel care.

So it's devastating.

Q. A geriatrician's involvement with a patient does not depend on the patient's age, does it?

A. As I explained, no. It depends, sometimes, on the care setting. So in my nursing homes we have some younger patients, but they have needs that can only be met in a nursing home. So, you know, we will take care of these patients.

And in my own geriatrics clinic, which we developed here at Nova Southeastern University, we were actually approached by a county organization that deals with people with developmental disabilities like Down's

syndrome or cerebral palsy. The life expectancy is shorter in those patients.

But, moreover, they have needs. They have frequent infections. They have mobility problems. They have problems with early dementia, behavioral issues where, you know, geriatricians actually ideally manage those things.

And if I can explain that? The strength of having people, you know, trained in geriatrics is that we are equipped to manage many of these issues without fragmenting the care of patients, you know, referring them to multiple specialists. We do consult, of course, if they need procedures, if we're not making any headway with a person's condition.

But that's the strength of a geriatrician, because we are actually trained to deal with many of these conditions.

Q. If Mr. Jaramillo is not currently being seen by a geriatrician, would you believe it would be medically appropriate for him to be seen by a geriatrician?

A. It's maybe. I cannot speak with a comfort level on the competency of his physicians. But it's maybe. And it just illustrates that even within nursing homes which -- you know, there are so few geriatricians in the country. There will never be enough geriatricians to provide care for all

of the adults.

But so many primary care providers actually will consult a geriatrician to provide an opinion or assist with some difficult aspect of care in their patients in the nursing home. So, you know, the nursing home provider may get a consult from a geriatrician. And I have been asked to do that.

Q. Is Mr. Jaramillo being currently seen by an endocrinologist?

A. I'm sorry. I don't remember that, and I did not note that.

Q. As a diabetic, would you expect that he would be seen by an endocrinologist?

A. I think that it's useful. If the diabetes is not well controlled, then possibly once a year to have some oversight from an endocrinologist is useful. I apologize. I don't remember whether he was seen by an endocrinologist.

Q. In your professional capacity treating patients, have you observed diabetes to adversely affect a diabetic individual's life expectancy?

MS. CURTIS: Objection, Your Honor. It's not specific enough to this particular -- it's -- the question itself is not specific, one, as an expert. It does not meet the standard for expert testimony. It is not specific to this particular patient. And for that reason, this is

not admissible testimony.

THE COURT: Counsel?

MS. RETTS: Your Honor, Ms. Curtis has challenged the expertise of this expert being able to give opinions relative to diabetes and how it affects life expectancy. And Dr. Pandya's personal observations of patients with diabetes form a basis for her general experience she then can utilize specifically to apply to this case.

In her report, she indicated that her experience and training led her to the conclusion that diabetes alone can reduce life expectancy by almost ten years.

THE COURT: Let me clarify something here. If counsel don't mind, I want to ask the doctor a question that will help me.

Doctor, you referenced, earlier, treatment of a condition in managing the patient or managing a patient's conditions. Help me to better understand the difference between managing and treating.

THE WITNESS: Okay. So it's really a continuum, you know. So chronic conditions such as heart failure or hypertension would have to be treated appropriately with lifestyle and/or medications or both, but then if it's a chronic long-term condition, so it would have to be managed.

For instance, you know, with hypertension, kidney

function would have to be checked. Hypertension can lead to heart failure, so that would need to be watched out for in a patient.

THE COURT: Right. So that part I understand. But I guess maybe my more specific question is: Do you do both?

THE WITNESS: Yes, indeed.

THE COURT: Because you referenced earlier having sometimes sought consultations outside of your practice.

THE WITNESS: Yes. Right. Indeed, we do do both. When we seek consultations is when, let's say, a patient needs a procedure. You know, somebody might need endoscopy, so that is not in my scope. That is a gastroenterologist.

If somebody had heart failure that was worsening and I could not identify a clear reason, then I would get the opinion of a cardiologist.

And let's say somebody needed a cardio-catheterization. You know, that's not in my scope, so I would certainly get consultation.

Mainly when a procedure is needed, and of course that's very -- you know, different physicians have various thresholds for getting consultations and various levels of comfort.

THE COURT: Yes, I understand what you're saying. All right. Now, you are board certified in endocrinology; is that correct?

THE WITNESS: Yes.

THE COURT: And diabetes or the treatment of diabetic conditions come under that; is that correct?

THE WITNESS: That's correct.

THE COURT: I take it that part is not disputed; is that correct, counsel?

MS. CURTIS: That's correct. That is not disputed.

THE COURT: All right. Now, I'm going to sustain the objection, but I'm going to permit Ms. Retts to rephrase her question.

I think the question as it stands is: In your professional capacity treating patients, have you observed diabetes to adversely affect a diabetic individual's life expectancy?

I would permit you -- and I think it's just too broad here. I'm sure there are thousands and thousands of different patient scenarios that would impact on any number of answers to that question.

But I would permit you to rephrase your question, something along the lines of inquiring about in her opinion, based upon her experience, her education, and her

training, does she have an opinion as to perhaps how a condition of diabetes would impact a person's -- I hesitate to use "life expectancy" because I think that is something that is, I think, very problematic. Would it affect a person's ability to progress in what would typically be the form of a person who doesn't have that condition, untreated, or perhaps not managed properly, whatever.

But I'll let you think about how you want to ask it.

Q. (By Ms. Retts) Dr. Pandya, taking into account your experience, your training, the peer-reviewed research that you have had published relative to diabetes, can you tell us how diabetes affects the condition of a person's health, and how that differs from the normal progression of an individual who did not have diabetes?

A. Yes. So individuals with diabetes are more prone to cardiovascular complications. That's the biggest cause of mortality.

So they're more likely to have hypertension, high cholesterol, more likely to have heart attacks, strokes, peripheral arterial disease, amputations. They are more likely to have infection. They are more likely to have pneumonia, sepsis.

People with diabetes are also, and I have observed this, more likely to develop pressure sores.

And one of the increasingly commonly recognized complications of diabetes, which was not well thought out before, was that of dementia. You know, we know that diabetes is the a of blindness, and it can cause renal failure, and it's the most common cause of dialysis in this country.

But it's being recognized that microvascular damage, you know, without even a significant history of stroke, but the hardening of the arteries in small, small vessels can cause dementia.

And diabetes is also associated with depression, so you see people are less interested in managing their disease. And when they have dementia, of course, it's a complex disease to manage. You know, you'll be on multiple medications, multiple insulin shots. So they are less able to do that. They become more dependent on others for care.

Q. Dr. Pandya, is it your opinion that Mr. Jaramillo's current disease burden will make him, to a reasonable degree of medical probability, more likely to develop further episodes of medical complications that he has previously experienced, including sepsis, pneumonia, venous thrombotic disease, C. diff.?

A. Yes.

Q. Cellulitis or osteomyelitis?

A. That is my opinion. Also, importantly, not only because he has diabetes but also because he is so functionally impaired, you know, so he can't do -- he is dependent on caregivers, so he needs -- you know, he is likely to have aspiration pneumonia. He is likely to have pressure sores.

His history -- I always look at patients and look back and see what their trajectory has been. And he already, in a short time, has had multiple hospitalizations for all of the complications we talked about earlier, the sepsis, delirium, pneumonia, urinary infections, kidney stones.

I believe he has a urinary catheter, if I'm not mistaken. He has a colostomy. You know, renal insufficiency.

He is at high risk for developing blood clots in his legs that could travel to his lungs. That could be fatal.

And, of course, his cognition and ability to interact and survive is very limited.

Q. Dr. Pandya, you were asked several questions about the studies relative to traumatic brain injury, and I want to go back and ask you some questions about that. When looking at a person who has some form of brain damage, from a medical perspective in treating that person, what is

important to you, the mode of injury or the complications from that injury?

MS. CURTIS: Your Honor, at this time I would object. That question is overly broad. This witness is not qualified to give any opinion concerning brain damage. I think clearly the evidence has been that using traumatic brain injury or mixing different forms of brain injury to come up with the same conclusion, there is no basis for those opinions.

I understand that for purposes of the hearing the Court may like to hear the answer, but I'd like to make sure that I've made a record of that objection.

THE COURT: You know, I'm going to sustain that objection here for those very reasons. Let's move on.

I'm going to recess for ten minutes, Doctor, so if you can -- don't hang up. Just understand I'm going to put you on hold, and I'll take the button off here in ten minute. All right?

THE WITNESS: All right. Thank you.

THE COURT: Thank you. All right. We'll be in recess for ten minutes.

(Witness' telephone put on mute.)

(Recess from 11:58 a.m. until 12:07 p.m.)

THE COURT: How much time here, Ms. Retts?

MS. RETTS: Five to ten minutes.

THE COURT: Okay. Ms. Curtis?
MS. CURTIS: Yes, ten minutes.
THE COURT: Okay. So we're going to wrap it up before 12:30. All right.
(Witness' telephone taken off mute.)
THE COURT: Doctor, are you there?
THE WITNESS: I'm here.
THE COURT: You're still with us. All right.
THE WITNESS: I was accosted by a couple of people, but I'm here.
THE COURT: You are very brave. All right. Let us continue. Counsel?
MS. RETTS: Thank you, Your Honor.
Q. (By Ms. Retts) Dr. Pandya, you have written quite a number of peer-reviewed articles on diabetes; is that correct?
A. Yes, ma'am.
Q. And that relates specifically to diabetes in the nursing home setting?
A. Yes. I have been instrumental -- I chaired the American Medical Directors' clinical practice guideline on management of diabetes in the long-term care setting, and that's been a widely used guideline; actually, even accepted by the Centers for Medicare and Medicaid as, you know, a reasonable approach, not the only way.

And I recently was invited by -- amongst other publications, I was also invited by the American Diabetes Association to present my perspective on the issues and challenges of managing diabetes in the long-term care setting, and that was included in their recent consensus statement of diabetes in older adults. So it was a joint project by the American Diabetes Association and the American Geriatrics Society.

And then I've -- as you can probably see from my CV, you can see I have worked with colleagues to write articles on the challenges of treating diabetes; use of applied care insulin; switching to newer insulins in the long-term care setting; what glucose tolerance should be in older adults; and so forth; skin tissue water content in patients with diabetes, compared to those without; and then the efficacy of some of the newer insulins in studies looking at younger versus older adults.

So that's a summary. And I -- oh, yes. I have written a book chapter in a book, a textbook on long-term care called A Pocket Guide to Long-term Care, and that was published, I believe, in 2011.

And we have a book that's in press by the American Diabetes Association, called -- you know, about diabetes and long-term care, and I was asked to write a chapter on the medical director's perspective, which I

wrote with a colleague of mine.

Q. Based upon your personal experience, training, peer-reviewed literature that you have authored or co-authored in the fields of diabetes and geriatrics, is it your opinion that Mr. Jaramillo's prognosis is poor?

MS. CURTIS: Objection, Your Honor. One, it's leading; and two, there is no peer-reviewed study. That opinion is not appropriate because while some things can be experience-based, this is just a sideways attempt to get into life expectancy.

Life expectancy under this set of circumstances needs to be based on some formula or some study that can be tested, especially given the statutorily based New Mexico life expectancy tables, as well as the federal government's published life expectancy tables.

And so for that reason, we would object to this expert being permitted to give that testimony.

THE COURT: Counsel?

MS. RETTS: Your Honor, the actuarial tables are not appropriate in this case because of the fact that the jury instructions in particular allow for the consideration of a patient's health and their habits.

This goes specifically to the patient's health. And Dr. Pandya is not giving a precise number. She's giving the jury a way to understand, from a medical

perspective, based upon her training and experience in treating patients with similar problems, what that prognosis means; what it means to have these complications; how that affects somebody's health.

Without such testimony, it's determined in a vacuum. The 81-year life expectancy is a number that's plucked from a book, for the average person. Mr. Jaramillo is not the average person.

And Dr. Pandya has looked through those medical records and applied her experience and training to those medical records, and has opinions based upon those medical records.

THE COURT: I'll hold in abeyance a decision on the objection. Let me hear the response. Go ahead and ask the question.

Q. (By Ms. Retts) Dr. Pandya, based upon your own personal experience, your training, your peer-reviewed literature that you have co-authored or authored in the areas of diabetes and geriatrics, is it your opinion that Mr. Jaramillo's prognosis is poor?

A. Yes.

MS. RETTS: Those are all the questions I have, Your Honor.

THE COURT: All right. Any redirect here?

MS. CURTIS: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. CURTIS:

Q. Dr. Pandya, this is Lisa Curtis again, since you can't see me.

A. Yes.

Q. Every complication that Mr. Jaramillo had was close in time to the actual event, within the first year to two years of his brain damage, correct?

A. I believe that is correct.

Q. And he --

A. I am not familiar with what has happened to him in the last couple of years.

Q. So he has healed through every one of those complications, correct?

A. Again, I would have to know what his trajectory has been most recently, what has happened to him in the last few years since, you know, or even in the last year since I reviewed his medical records. That would really be important.

Q. Right. So the information or the answer that you just gave to opposing counsel a few moments ago, you don't know what his prognosis is, really, for the future because you don't know what his last several years of treatment have consisted of or whether he has had even any complications whatsoever?

A. Well, one, it's true that I don't know, especially in the last year or so, what complications he has had. I think that some of the problems he has had are not necessarily curable problems; I mean, having a colostomy, being prone to medical problems, and this is not a curable problem; having kidney stones; and generally he will continue to get urinary or kidney infections.

He will still be -- he'll continue to be prone to clostridium difficile infections.

He is very much prone to pressure sores because of his poor mobility.

And, as I have said, he is very much prone to developing further venous thromboembolisms, you know, either deep vein thrombosis of the legs or blood clots in the lungs.

Q. Well, Doctor, let's take those one at a time. All right? You're not qualified to give an expert opinion on whether he's prone to Ogilvie's or megacolon? I mean, no one even know what causes those, right? That would definitely be the area for a gastroenterologist?

A. Except that I have seen that once people get it, they tend to get it frequently.

Q. Well, there is research on this topic, though, Ogilvie syndrome or megacolon, that you are unfamiliar with, correct?

A. That's correct. That's correct.
Q. And then in recent years, you just don't know that Mr. Jaramillo has actually been very healthy; he hasn't been to the hospital at all?
MS. RETTS: Your Honor, I would object to the extent that necessarily in a lawsuit, you have discovery cut off at a certain point in time, and so when we do not have current records, to the extent that there is a challenge based upon records that haven't been produced thus far, it's not an appropriate challenge, if we don't have medical records from the most current period of time, because the discovery ends at that period of time.
MS. CURTIS: Your Honor, that's very confusing.
THE COURT: The doctor has already said she is not familiar with any of the treatment, or any of the progress of his condition, or what the treatments have consisted of over the last few years. If I understood that, that was her testimony, was it not?
MS. CURTIS: That is my understanding, Your Honor.
THE COURT: So you're asking her what, then? To speculate?
MS. CURTIS: No. You know, that's a very good -- that's a very good direction, Your Honor, and I will -- let me do it this way, since she's an expert.

THE COURT: All right.

Q. (By Ms. Curtis) Dr. Pandya, I do acknowledge that you are an expert in diabetes management and treatment, and in that setting I'm allowed to ask you hypothetical questions.

So if in fact Mr. Jaramillo had healed through all of his complications and has been very healthy for the last several years, would that give you any information about what his future prognosis is?

A. That would be difficult to say, because a patient can have periods of stability and then experience a sudden decline. And then my biggest concern for saying that -- you know, my biggest reason for saying that he's prone to these complications again is his total, you know, debility, dependence on care, feeding. He's not able to function normally.

And as I explained before, he's therefore still prone to further complications.

Q. And let me just be clear. You're saying not by a reasonable medical probability that he will suffer any of those conditions, just that he could; is that correct?

A. Well, I think there is reasonable probability that he will, and I'm saying this based on my experience. I have had long, you know, longitudinal relationships with patients and have taken care of them over many, many years.

So it's not a question of "if." It's a question of "when."

Q. So by reasonable medical probability, do you believe that Jose Jaramillo will have further hospitalizations?

A. Yes.

Q. And how many do you believe he'll have?

A. It's impossible to say. I really could not say.

Q. So you understand that there is a cost to that care and treatment?

A. I'm sorry? There is --

Q. You understand that if he is reasonably probable to need hospitalizations in the future, that there is a cost for that care and treatment?

MS. RETTS: Your Honor, I would object to the relevance. This is an attempt to back-door the problems and their cost-of-care expert's report.

MS. CURTIS: Your Honor?

THE COURT: Yes?

MS. CURTIS: I believe there has been lengthy testimony about future prognosis and the fact that he's going to need additional care.

THE COURT: I'll permit it. Let's move on. Answer the question.

Q. (By Ms. Curtis) Doctor, can you answer that question, please?

A. Yes. Of course. As far as any hospitalizations, further hospitalizations, there is always cost.

Q. Do you agree with the treatment? At least up to the time of the records that counsel has provided you, they show that he has had good and appropriate care and treatment of the sequelae from his invasive pneumococcal disease?

A. I think that certainly he has had appropriate care, you know, following his pneumococcal disease, for all of the complications that he presented, both medical and functional and nutritional. Yes, I think the care has been appropriate.

Q. All right. Because I don't know exactly when your records end. Do you have an opinion as to whether his diabetes has been in good control since the time of his residence at Sagecrest?

A. I'm sorry. I don't have all my notes from that time. I'm looking at the report that I was asked to prepare specifically, you know, about his diabetes care. Certainly when he was diagnosed, into -- I do have a little more information -- in June 2007 he was treated very promptly with two oral medications. And in September 2007 his hemoglobin A1c was 7.1 percent, and in December it was as low as 5.8 percent.

So I think that his care has been reasonable.

And I wrote in my notes that between January and April he had excellent fasting blood glucose levels, and he was monitored appropriately, and I did not --

THE COURT REPORTER: I'm sorry, but I can't hear her.

THE COURT: Doctor? Doctor?

THE WITNESS: Yes?

THE COURT: Finish the last three sentences, because my court reporter didn't hear that.

THE WITNESS: Okay.

A. So in September 2007, the same year he was diagnosed, his hemoglobin A1c was 7.7 percent, which is pretty good. And in December it came down. In December 2007, it was as low as 5.8 percent.

And he received examinations, which indicate good care.

And between January and April, I did note from his records that he had good fasting blood glucose levels. He was monitored with repeat of blood glucoses. He was on two oral medications.

So let me see if I note anything further.

I did not make specific comments beyond that time about his diabetes management.

Q. All right. So, again, since you're an expert, the question I asked you was Sagecrest, and I don't believe

that encompassed any of the areas that you were talking about.

Can you tell us, do you know whether his diabetes was in good control during the time he has been a resident at Sagecrest?

A. Could you please let me know what year or when that was?

Q. He has been there approximately three years.

A. So the past three years?

Q. Yes. Do you have those records? Or do you have an opinion that you're going to express at trial about whether his diabetes has been under good control for the last three years?

A. I did not make specific notes about his blood sugars at that time, so I'm sorry, I cannot tell you anything more specific, you know, about those previous -- those recent years.

THE COURT: Let's move on.

MS. CURTIS: Yes.

Q. All right. So let me just ask you a couple of broad questions in response to the answers that you gave counsel. More than 51 percent -- 51 percent or greater of people with diabetes do not have dementia, correct?

A. I'm sorry? Can you say that again?

Q. Sure. Of all the people that have diabetes, 51 percent

or greater do not have dementia, correct?
A. I don't know the exact percentage or what, you know, studies you are referring to, but I think it's fair to say that the majority of people with diabetes do not have dementia. But that the literature does show that among people with diabetes, they are more likely to have vascular dementia or Alzheimer's dementia than people without diabetes.

And actually, I do remember, I gave a keynote address on diabetes and dementia at our regional Alzheimer's conference, and people with diabetes are 50 percent more likely to develop Alzheimer's dementia than people without diabetes.
Q. All right. But that doesn't mean that over 50 percent or the majority of people with diabetes have dementia, right? Because they don't?
A. No. It does not mean the same thing.
Q. Yeah. All right.

So I would ask you just hypothetically assuming that Jose Jaramillo has well-controlled diabetes and has had well-controlled diabetes since he was diagnosed in 2007, he is unlikely, if he continues to be well controlled, to have any of the long-term complications that you see in diabetics that do not have well-controlled disease?

A. I'm not sure if it's that simple to say that, that he is unlikely to have any complications. I think just by virtue of the length of the time somebody has diabetes, they are likely to have some complications.

I don't think it's possible just to say that his diabetes is well controlled, that's why we can reasonably say that he won't have any long-term sequelae, you know, long-term complications pertaining to diabetes.

I think the length of diabetes -- and I also note that he also had hyperlipidemia. No. Actually, I'm sorry. At least in the beginning, 2007.

But I think with his duration of diabetes, itself, I don't think I could safely say that he's unlikely to have complications because it's well controlled. That has not been my experience.

Q. Let me ask that question just in reverse, and this will just be my last area. And that is: The people that have uncontrolled diabetes are most likely to have long-term complications, correct?

A. That is correct.

Q. Thank you.

A. That is what the literature supports.

Q. Thank you.

MS. CURTIS: Thank you, Judge. I don't have any further questions.

THE COURT: All right. I have one question, Doctor, and you answered it earlier, but that was when we had a little trouble here with the real-time, and I didn't capture it. I can't find it, so I'm going to ask you again, and it's just for my own benefit.

You had mentioned early on -- you explained the difference between a gerontologist and a geriatrician.

THE WITNESS: Yes.

THE COURT: Clarify the differences for me again.

THE WITNESS: Okay. So a gerontologist usually is a scientist, a master's, a Ph.D. level, but not a medically-trained physician who specializes in the study of aging. So they might specialize in like the psychology of aging, you know, physiologic decline, muscle and bone changes. They look at the study of aging and do research in that area.

A geriatrician, while they may still be doing research, are usually physicians who are trained in internal medicine or family medicine, who have additional fellowship training in geriatrics, as I have explained in my own institution. And then, you know, they can sit for a board certifying exam. And their clinical, you know, practice is generally focused in the area of taking care of older adults in different sites. You know, it may be hospice care, long-term care settings, geriatric settings,

and so forth, hospital service.

THE COURT: Okay. And one other question. What is the, if there is one, cut-off point for making the diagnosis of diabetes, and what numerical percentage range is that?

THE WITNESS: Oh, okay. Yes. That's -- that's important because that has changed. About five to, say, three years or so ago, diabetes was diagnosed as either with an abnormal fasting glucose greater than 126, or a random glucose or post-meal glucose greater than 200.

And recently, in the last three years or so, the American Diabetes Association and all the international associations have reached the conclusion that it is now okay to measure the hemoglobin A1c level, which is not the blood sugar; it's the percentage of your hemoglobin that is attached to glucose.

THE COURT: Right. And it measures a three-month period.

THE WITNESS: Right.

THE COURT: That part I understand.

THE WITNESS: That gives you an idea. And so you can diagnose diabetes now if somebody's A1c is greater than 6.5 percent.

THE COURT: All right. Counsel, in lieu of my questions, are there any follow-ups on those points?

MS. CURTIS: No, Judge.

THE COURT: Ms. Retts?

MS. RETTS: No, Judge.

THE COURT: Doctor, I thank you, and I'm going to release you at this time.

THE WITNESS: Thank you.

THE COURT: All right. Have a good rest of the day. I think we're going to get rain, if not snow, here, and I recall that you are in Florida. Lucky you.

THE WITNESS: I am. Thank you so much.

THE COURT: Goodbye.

THE WITNESS: Goodbye.

(The witness' phone was disconnected.)

THE COURT: Okay. The Court is taking this matter under advisement. All right?

Now, are both of you going to be here, then, for the 2:00 Daubert hearing? Or will there be other counsel?

MS. CURTIS: I will be doing the argument. I don't know that I won't have additional support.

THE COURT: Okay.

MS. RETTS: It will just be me, Your Honor.

THE COURT: So my question is, we can do this at the end of the day. It doesn't really matter. But I want to see, do I have copies of the references that you were

questioning the doctor on?

MS. CURTIS: I can give you copies.

THE COURT: Yes. I did have Carol copy the --

MS. CURTIS: Number 4.

THE COURT: -- Number 4, Life Expectancy After Traumatic Brain Injury. But to the extent you questioned the doctor specifically on any of these articles or treatises, I would like to have copies, so if you could meet and confer to make sure that I have the part that's relevant. I don't need the whole book, if that's what you are looking at. But I do have Number 4, which is the Life Expectancy. Those can be provided to me at a later time.

And same thing to you, Ms. Retts, if you're going to be referring to anything, as well.

And I take it there is no objection to the Court considering those, because it will help me to refer back to the real-time and understand the context of the doctor's testimony.

MS. CURTIS: Thank you.

THE COURT: All right. Let's take a break here, and we'll see you back here at 2:00 with our next witness.

Thank you.

MS. RETTS: Thank you, Judge.

THE COURT: All right. We'll be in recess.

(Recess from 12:33 p.m. until 2:05 p.m.)

DAUBERT MOTION

(In open court at 2:05 p.m.)

THE COURT: Good afternoon again.

MS. CURTIS: Good afternoon, Judge.

MS. RETTS: Good afternoon.

THE COURT: You may be seated, and let us resume here.

We are back on the record in the case of Hart v. Corrections Corporation of America, et al., this being on the Civil Docket, 11-CV-267.

Just give me a moment here. The Court will note the appearances of Ms. Curtis for the plaintiff and Ms. Retts for the defendants here. All right.

And thank you for preparing the copies of the reports and documents that were referred to in this morning's testimony. I appreciate that. And I take it there is no objection to the Court considering these as part of its analysis of today's issue?

MS. RETTS: No, Your Honor. I just wanted to make clear that those are excerpts; they're not the full documents.

THE COURT: But this is the relevant part?

MS. RETTS: Yes.

THE COURT: That's all I need. Thank you so much.

Let us proceed at this time with the second hearing that we have set here under Daubert in the Court's gatekeeping responsibilities, and that is the plaintiff's Daubert motion to exclude expert testimony of Lowell Young, M.D. The motion being filed on the docket is Document Number 124. So are you going to proceed, counsel, in the same fashion we did this morning, as far as the protocol?

MS. CURTIS: Yes, Your Honor.

THE COURT: All right. Ms. Curtis, I do recognize you, then, at this time. We do have Dr. Young on the phone. Do you want him sworn in at that point?

MS. CURTIS: Might as well. Yes.

THE COURT: Okay. Dr. Young, good afternoon. This is Judge Armijo.

THE WITNESS: Good afternoon, Your Honor.

COURTROOM DEPUTY CAROL BEVEL: Would you please raise your right hand. You do solemnly swear that your testimony in this matter shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

COURTROOM DEPUTY CAROL BEVEL: Would you please state your name and spell your last name for the record.

THE WITNESS: Lowell Sung-Yi Young. The last name is spelled Y-O-U-N-G.

THE COURT: You may proceed.

MS. CURTIS: Thank you, Your Honor.

Your Honor, generally, as the Court is aware, we have made an objection to Dr. Lowell Young testifying as an expert for the defendants in this case, not because Dr. Young is not an expert in some things, but that he is not an expert qualified to testify in this case for causation, which is what he has been offered on.

The defendants, in their response, cited to the Ralston case -- that would be Ralston v. Smith and Nephew Richards, which is a 2001 Tenth Circuit case -- concerning the admission of expert testimony, citing Kumho Tire extensively. It's not that any expert can testify. They must stay within the reasonable confine of their subject area.

The issue around the reasonable confine of subject area has to do with what the expert can contribute at trial to the jury. They must be able to assist the jury with an issue that is in dispute. Dr. Young, while he is certainly a very qualified medical researcher and animal researcher, has not practiced medicine, as you see in Exhibit 1 to the motion, Judge, for 13 years.

He does very important research on a particular bacteria that evidences in late-stage AIDS patients, and he has been qualified as an expert in New Mexico on that particular subject.

However, what he wishes to testify today to, and at the trial of this case, has to do with the ability of the pneumococcal vaccine to have stopped Jose Jaramillo from developing invasive pneumococcal disease.

The second challenge to Dr. Young is the basis for his opinion. This basis, while the Court I believe will understand the difference, is something that I will seek to bring out through Dr. Young, is that he wishes there to be randomized controlled trials, which is a particular level of medical research, in order for the plaintiff to be able to prove that in fact this vaccine, which is widely accepted as necessary by the CDC and the ACIP, which is a committee of the CDC, as needing to be given to all diabetics, that he does not believe, because we are without controlled -- I'm sorry -- randomized controlled trials, that he could testify that it would have been effective with regard to Jose Jaramillo.

What Dr. Young is doing is raising the bar on the burden of proof so high that it could never be met if this was the requirement.

The important difference, Judge, that I'd like to bring out quickly before I ask questions of Dr. Young, is that the study that Dr. Martin relied on is a very well accepted, in fact "the" study, on effectiveness of pneumococcal vaccine on invasive pneumococcal disease.

It's called the Cochrane Database Review. It had 18,000 patients in it, and it is accepted by all other entities as strong evidence for worldwide vaccine administration. But that is called a case controlled trial.

Case controlled trials are frequently used to justify interventions in both public health applications like vaccination of relatively unusual diseases, as well as in clinical medicine.

The standard, which is randomized controlled trials, are simply impractical. That's why they're not done on everything. They cannot be done on a rare disease like invasive pneumococcal disease.

Out of the Cochrane study that had 18,634 people, out of that group that was vaccinated, only 15 got pneumonia at all. And so the incidence of getting pneumonia, once vaccinated, is extraordinarily low.

But, then, pneumonia and invasive pneumococcal disease are not the same entity, and this is a very important fact in the case, as we argued in our motion and as Dr. Young has admitted in the testimony that we provided, because just like how the flu can lead to adult respiratory distress syndrome, they are not the same thing.

Pneumonia, in certain populations, if the

vaccine is not provided, can lead to invasive pneumococcal disease, which is what Jose Jaramillo had; and that is, he had bacterial meningitis that caused brain damage.

So the level of proof that Dr. Young is requiring to find causation is not the legal burden, which is greater than 50 percent. He has raised it to a completely different level. And, in addition, the two studies as recited in our motion, the Ortquist study and -- and I want to make sure I say this right -- the Simberkoff studies are studies concerning pneumococcal vaccine and pneumonia. They are not invasive pneumococcal disease studies.

So he has got two studies he's talking about, but as he has admitted in his deposition, pneumonia and invasive pneumococcal disease are different diseases. One leads from the other, but you cannot call those studies as being remotely related.

Just so the Court knows, it's not that we believe that Jose Jaramillo wouldn't have contracted pneumonia, potentially, if vaccinated. That can happen.

The whole issue in this case is, if vaccinated, it would never have come to the level of invasive pneumococcal disease. He would have had a short run of pneumonia, and he would have gone right back to CCA's institution.

Dr. Young, now at this point in time I would like to ask you a few questions, if I may, Your Honor?

THE COURT: You may. Doctor, let me just have you advise me if you can't hear me, and this is Judge Armijo, or the attorneys. They are speaking with a mike, but I want to be sure that you're able to clearly hear them. All right?

THE WITNESS: Yes. I can hear you. The attorney's voice was very faint.

THE COURT: Okay. Well, I will ask her to speak up.

THE WITNESS: All right.

THE COURT: Carol, there may be a way to adjust that mike. Just give us a second here. All right. Ms. Curtis, say a few words and see if that helps.

MS. CURTIS: Dr. Young, this is Lisa Curtis. Can you hear me?

THE WITNESS: Yes, I can.

THE COURT: Okay.

THE WITNESS: Please continue at that pace.

THE COURT: She will try.

MS. CURTIS: Yes, I will. And I'm not normally thought of as soft-spoken, so I don't think you'll have any trouble hearing me.

LOWELL SUNG-YI YOUNG, M.D. (Appearing Telephonically), after having been first duly sworn under oath, was questioned and testified telephonically as follows:

DIRECT EXAMINATION

BY MS. CURTIS:

Q. Dr. Young, you heard my argument a few moments ago, correct?

A. (WITNESS TESTIFYING TELEPHONICALLY) Pardon?

Q. Were you capable of hearing the argument I just made --

A. Yes.

Q. -- to the judge? Okay. Thank you. It is true, isn't it, Dr. Young, that you have not practiced medicine since the year 2000?

A. That is true.

Q. And that the work that you're doing, and have been doing, is animal research on beige mice concerning mycroavium bacterium?

A. Mycobacterium avium.

Q. Thank you. And you have not treated, as a physician, any patient, any human patient, with any invasive infectious disease?

A. That is correct, in the last 13 years.

Q. Also, the one time you have been qualified in a federal court in New Mexico to testify, it was with regard to that

very specific bacterium work that you're doing?
A. That is true.
Q. Now, Doctor, am I correct that your disagreement with what we've been calling pneumococcal vaccine, or PPV-23, is that there are no specific randomized controlled trials in people with diabetes?
A. That demonstrate effectiveness in prevention of pneumococcal disease of any kind.
Q. Right. There's no specific randomized controlled trials?
A. That's correct.
Q. But you do recognize that there are case controlled studies, like the Cochrane study, that find the efficacy rate of PPV, or pneumococcal vaccine, to be generally 74 percent?
A. That is an overall figure for pneumococcal disease. It is not an overall figure for pneumococcal meningitis.
Q. Right. Because invasive pneumococcal disease can be several things? Bacteremia? Correct?
A. Correct.
Q. Or meningitis?
A. Correct.
Q. And I'm forgetting the third. What is the third?
A. Endocarditis.
Q. Endocarditis. Okay. So what these are, are additional

invasive diseases that come out of pneumonia; is that correct?

A. Invasive diseases that what pneumonia?

Q. That come out of pneumonia?

A. No, they don't turn out as pneumonia. They can accompany pneumonia.

Q. Okay. I'm sorry. We are having just a little bit of difficulty hearing each other, so I will try to speak up a little bit.

Pneumonia and invasive pneumococcal disease are not the same disease; is that correct?

A. That is correct.

Q. And the Simberkoff and Ortquist studies deal with pneumococcal vaccine and pneumonia only, correct?

A. That's correct.

Q. And so the coverage of pneumococcal vaccine, you agree, don't you, Doctor, that the coverage is between 80 and 90 percent of all serotypes for invasive pneumococcal disease?

A. I agree with that.

Q. Now, this may sound like a simple question, but 80 to 90 percent is much higher than 51 percent, correct?

A. Yes.

Q. And the efficacy that the Cochrane study shows is 74 percent, which is much higher than 51 percent, correct?

A. I would agree with that.

Q. All right, sir. So your sole dispute with the effectiveness of pneumococcal vaccine for Jose Jaramillo is that there has not been a randomized controlled trial in diabetics?

A. That is correct. There is no evidence that in patients with underlying diabetes, that this vaccine is protective against any type of pneumococcal disease, whether it's pneumococcal pneumonia, pneumococcal meningitis, pneumococcal bacteremia, or pneumococcal endocarditis.

Q. You recognize, as I believe you discussed in your deposition, that the Cochrane database had over 18,000 patients that had all different types of underlying health situations, including diabetes?

A. Yes.

Q. All right. And that out of those 18,000 patients, only 15 patients even got any form of pneumococcal disease, if vaccinated?

A. Right.

Q. All right. So although you recognize that the Cochrane database review contains people with diabetes, you are unwilling to say that that study is sufficient to show what the efficacy of the pneumococcal disease vaccine would be in Jose Jaramillo?

A. Right. It's clearly inadequate. Although small numbers of cases of pneumococcal disease and a limited

number of patients with underlying diabetes, you cannot say that based on those 18,000 patients, that diabetics were protected.

Q. And that's because you would want a randomized controlled trial, to be able to say that diabetics were protected with the pneumococcal vaccine, correct?

A. Or even a case controlled study. There isn't a case controlled study that shows that there is protection.

Q. Other than the fact that there are diabetics in the Cochrane study?

A. There are diabetics, but they are not specifically a population of diabetics that have been protected.

Q. Do you recognize, Dr. Young, the reason why randomized controlled trials are simply impractical in a rare disease like invasive pneumococcal disease?

A. I don't think they are impractical. I think they could have been done. If the manufacturer of the vaccine had wanted to study it, it could have been studied.

Q. 18,000 people is quite a large number for a study, isn't it?

A. That's true. But for influenza vaccine, tens of thousands of people are vaccinated.

Q. The case controlled studies, do you agree, are frequently used to justify interventions in both public health and clinical medicine?

A. Yes.
Q. And you recognize that the Cochrane study is one of the significant bases for the ACIP's finding and the CDC's determination that all diabetics should be vaccinated with pneumococcal vaccine?
A. That may be part of their rationale, but the evidence isn't there.
Q. So you just disagree with the CDC and the ACIP because there are no specific randomized controlled trials for diabetics?
A. That is my position.
MS. CURTIS: Your Honor, I don't have any further questions at this time. I pass the witness.
THE COURT: All right.
MS. RETTS: Your Honor, before I begin with questions of Dr. Young, I'd just like to address a few --
THE WITNESS: Could you speak up? I can't hear you.
THE COURT: Just a minute, Doctor. Here's what we're going to do.
THE WITNESS: Yes.
THE COURT: I'm going to put you on hold for a minute.
THE WITNESS: Sure.
THE COURT: Just stand by.

(Witness' telephone put on mute.)

THE COURT: Let's prop it up with a book or something here. I think the closer you get -- Carol, why don't you try this, for lack of a better solution. The other witness had no problems, but he may be hard of hearing. See if that will work. Do you think? Is it slipping?

MS. RETTS: We'll address it if it slips.

THE COURT: All right.

(Witness' telephone taken off mute.)

THE COURT: Let's try it.

THE WITNESS: Okay. That's better.

THE COURT: Well, that was the judge. All right. Counsel, go ahead.

MS. RETTS: I will try to project.

THE COURT: All right.

MS. RETTS: Your Honor, I would like to address a few points in plaintiff's Daubert motion, and argument, before continuing with questioning of Dr. Young.

THE COURT: Can you hear that, Dr. Young?

THE WITNESS: Yes.

THE COURT: All right.

MS. RETTS: Particularly as to the first point of Dr. Young's qualifications, Dr. Young has extensive experience and training in the infectious disease arena,

including actual treatment of patients. There is nothing within Daubert or any of its progeny that suggests that a physician who is now not involved in clinical practice, but was for a substantial length of time, is somehow unqualified.

Dr. Young's animal research has also provided him with the requisite skills to be able to analyze critically the studies, such as the one that Ms. Curtis pointed out.

Indeed, if the plaintiff's argument is accepted, then their expert is likewise to be excluded because his specialty is in sexually transmitted diseases.

Dr. Young has the requisite background from his clinical practice.

I would also note that a lot of the problems that plaintiff points out in the testimony are not from Dr. Young's opinions, but from an attempt to inject into his deposition areas that he is not opining about.

Dr. Young is not testifying about the standard of care. He was asked questions about what the California Pacific Medical Center does currently with regard to vaccination, which formed a basis for plaintiff's argument in their motion that he was not qualified. But whether the California Pacific Medical Center currently has a policy of vaccinating patients is not related to the issue of causation in this case, because one can have a policy that

is based upon factors different than the actual medical evidence at issue.

What we're talking about here is the actual medical evidence at issue relative to efficacy of this vaccine in the diabetic population for specifically preventing pneumococcal meningitis.

The plaintiff has indicated that pneumonia is not relevant to the inquiry at hand and that the studies relied upon by Dr. Young, relative to pneumonia, don't make a difference and don't support his analysis.

However, pneumonia is very relevant for a few considerations.

First, in this case it is undisputed that Mr. Jaramillo likely would have gone on to develop pneumonia even if he was vaccinated. So when we're, again, looking at the "but for" component of plaintiff's burden of proof, we have to look at what the difference is between the vaccination versus the non-vaccination.

So the pneumonia is important to that issue, because if he would have developed pneumonia, what are the complications from that pneumonia that he could still be experiencing today? What is the hospital course? What is that realm of experience?

It's not just simply that he has pneumococcal meningitis at this point. It's that he would have had

pneumonia regardless, and there has been no attempt to tease that out, and that also forms the basis of some of our motions in limine.

Pneumonia is also important because pneumonia is the precursor, in the majority of cases, to pneumococcal meningitis, which I will have demonstrated through Dr. Young's testimony, so that it's very illogical to suggest that one can contract pneumococcal meningitis if they don't contract an underlying precursor illness.

So if the vaccine is not particularly effective at preventing pneumonia, then why should it be particularly effective at preventing pneumococcal meningitis, which is the step-through? So it has to step through from the pneumonia, which is the most common cause, to a bloodstream infection, and then cross the blood-brain barrier for the pneumococcal meningitis.

And there are absolutely no studies whatsoever that have looked specifically at the blood-brain barrier jump, the Pneumovax 23, and showed that that vaccine has some significant protection in preventing that jump.

Instead, the studies that have been done lump together pneumococcal meningitis with other invasive forms of pneumococcal disease which are fundamentally different because they don't involve that blood-brain barrier jump.

CROSS-EXAMINATION

BY MS. RETTS:

Q. Dr. Young, could you please give us a synopsis of your educational background?

A. Yes. I graduated from Princeton University in 1960; from the Harvard Medical School in 1964; and I did my internship and residency in the Cornell program in New York City from 1964 to 1967.

I spent two years at the Centers for Disease Control, the CDC, from 1967 to 1969. And from 1969 to 1970, I took a year of infectious disease fellowship at the Memorial Sloan-Kettering Cancer Center, after which I joined the staff of the Memorial Sloan-Kettering Cancer Center.

Q. And can you give us a synopsis of the positions that you have held during your career where you have treated patients for infectious diseases?

A. Yes. From 1970 to 1972, I was on the staff of the Infectious Disease Service at Memorial Sloan-Kettering Cancer Center. From 1972 to 1985, I was on the faculty of the UCLA School of Medicine, where I was an assistant associate and then full professor of medicine.

And since 1985, I've been in San Francisco. From 1985 to the year 2000, I was chief of the Division of Infectious Diseases at California Pacific Medical Center,

and clinical professor of medicine at the University of California, San Francisco.

Q. Could you tell us what your duties were while at the CDC?

A. Yes. I was a member of the special pathogens unit, which had responsibility for diseases such as meningococci influenza and tularemia.

Q. Can you tell us what your duties were when you were the chief of the Division of Infectious Diseases at the California Pacific Medical Center?

A. I was responsible for the consultation services in infectious diseases; the teaching of medical students, residents, and fellows; as well as in-patient consultations, both in medicine and in surgery, for problems of infectious disease.

Q. In your professional experiences where you have treated patients, have you treated patients who have had pneumococcal infections?

A. Absolutely.

Q. Have you treated patients who have had pneumococcal meningitis?

A. Yes.

Q. Have you treated patients who have had pneumonia?

A. Yes.

Q. You also have been involved in research on infectious

diseases; is that correct?
A. That is correct.
Q. And can you give us a synopsis of the research that you have done that relates to pneumococcus?
A. Right. Well, I was interested, in the first part of my career, in Gram-negative sepsis, and in particular the sharing of antigens, or parts of the outercoat of the layer of the germ, of the pneumococcus as well as a germ called Klebsiella pneumoniae. We published several studies of what's called the cross-reaction.

I have been interested in sepsis, sepsis syndrome, Gram-negative sepsis, and there are similarities and there are differences between that and pneumococcal disease.
Q. Did Mr. Jaramillo have sepsis?
A. Yes.
Q. Have you written research papers specific to meningococcal disease?
A. Yes. You mean pneumococcal disease?
Q. Pneumococcal disease. Sorry.
A. Yes.
Q. Have you written research papers specific to meningitis?
A. No.
Q. Have you conducted your own independent research

relative to pneumococcus?
A. Not independent research. I've used the vaccine, but I haven't been part of any independent research effort.
Q. In your teaching capacities, have you instructed students relative to the treatment of patients who have pneumococcal meningitis?
A. Yes.
Q. Have you, in your teaching capacities, taught students relative to the treatment of patients who may have other pneumococcal illnesses?
A. Yes.
Q. To help us get a better understanding of what pneumococcal meningitis is, can you explain the disease process of how a pneumococcal infection can progress to pneumococcal meningitis?
A. Right. Right. What you need for pneumococcal meningitis is what's known as a focus. There has to be a part of the body where the germ enters the bloodstream. This can be anywhere in the respiratory tract. So the pneumococcus is the respiratory pathogen.

And when we say "the respiratory tract," we're saying the lungs, the sinuses, the ears.

The organism crosses into the bloodstream of the patient and then circulates in a process which is called bacteremia. All that "bacteremia" stands for is meaning

bacteria in the blood.

There is what is known as the blood-brain barrier, the barrier between the bloodstream and the cerebral spinal fluid which circulates around the brain.

The germ has to cross the blood-brain barrier. It --

MS. CURTIS: Your Honor, at this time I would like to object.

THE COURT: Just a minute, Doctor.

MS. CURTIS: I would like to object that the opinion testimony that Dr. Young is entering into right now is not only not in his report, but also not in his deposition and not in his expert witness designation. And so we'd move to strike him based on what he was offered to testify about, as well as what he stated in his report and what he stated in his deposition.

And so this new line of expert testimony is inappropriate, and I would ask that he not be allowed to proceed.

THE COURT: Counsel?

MS. RETTS: I would disagree with that characterization, Your Honor. It is adequately covered in Dr. Young's report, and this is the basic foundation for the scientific issues in this case. And, in fact, in Dr. Young's deposition, and I'll cite pages, he has given

testimony on Page 26 relative to pneumonia and its relation to invasive pneumococcal disease. He has given statements about how it is unlikely that there would be any effect on a patient, any effect of a vaccine on a patient when there's no underlying evidence that there is any effect on pneumonia because pneumococcal meningitis is a different entity.

That counsel chose not to question him further on that is not a non-disclosure issue.

THE COURT: Overruled.

I think when you left off, Doctor, we were talking about the blood-brain barrier.

A. Yes. The blood-brain barrier is the barrier between the bloodstream and the cerebral spinal fluid. Now, meningitis refers to an inflammation of the lining of the brain. The meninges are the membranes which encase the brain and the spinal cord.

So when you have meningitis, you have infection of the layer that covers the brain and of the cerebral spinal fluid.

Q. And there's a difference between viral meningitis and bacterial meningitis, correct?

A. Absolutely. Viral meningitis is usually benign, self-limited, and there's only one form that can be treated medically with antibiotics.

Q. And what we're talking about in this case is a bacterial meningitis, correct?
A. Absolutely. Bacteria are the creatures which penicillin-type drugs will target.
Q. Is pneumonia the most common precursor of pneumococcal meningitis?
A. Yes.
Q. Have there been research articles or data published that support that?
A. Yes.
Q. Is there any research, either in a clinical trial or a cohort study, that shows that -- strike that.

Is there any research that has been done, in a clinical trial or a cohort study, specific to whether the vaccine at issue in this litigation prevents pneumococcal meningitis?
A. No.
Q. Now, opposing counsel asked you several questions about research trials, but you also agree that there is no cohort study supporting efficacy of Pneumovax 23 in preventing pneumococcal meningitis specifically in a diabetic population?
A. That is my position.

MS. CURTIS: I object, Your Honor.

THE COURT: Just a moment. Hold on. Before you

answer, Doctor, let me hear the objection.

MS. CURTIS: I'm just going to object. I mean, counsel is leading the expert, as opposed to asking questions that are non-leading.

THE COURT: Rephrase your question, counsel.

Q. (By Ms. Retts) Dr. Young, you were asked some questions about research trials and your opinions as they relate to research trials. When you considered your conclusions and opinions in this case, did you look for data other than that generated from controlled research trials?

A. Right. I looked for all the data that was available to indicate that patients with underlying diabetes were protected by Pneumovax, and could find no evidence for that.

MS. RETTS: I don't have any further questions, Your Honor.

THE COURT: Okay. Ms. Curtis, before you do that, let me talk to my staff for just a moment.

MS. CURTIS: Yes.

THE COURT: Just hold on, Doctor.

THE WITNESS: Okay.

(A discussion was held off the record between the Court and Courtroom Deputy Carol Bevel.)

THE COURT: Okay. Ms. Curtis?

MS. CURTIS: Thank you, Judge. Dr. Young, can you hear us?

THE COURT: We're back on the record. Can you hear us all right?

THE WITNESS: Yes, I can hear you fine, Judge.

THE COURT: All right. Let's continue.

MS. CURTIS: I could tell, somehow, he wasn't with us.

THE COURT: That's because the Judge forgot to push the button. That does happen. But it is not a "Send" button.

MS. CURTIS: Yes.

REDIRECT EXAMINATION

BY MS. CURTIS:

Q. Dr. Young, you just said a few moments ago to opposing counsel that there is no evidence of the protective effect of the pneumococcal vaccine on diabetics?

A. Correct.

Q. That's not completely accurate, correct? I believe your testimony earlier was that you recognize the Cochrane study included diabetics, and that the finding of that study was that pneumococcal vaccine was protective?

A. Right. But there was -- the diabetic population wasn't singled out in that Cochrane analysis.

Q. Right. But you do admit that there is some evidence

that pneumococcal vaccine is protective, as stated in the Cochrane study which included diabetics?

A. No, I disagree with that. I don't think the diabetic population was specifically subgroup analyzed in the Cochrane study.

Q. I didn't say that they were subgroup analyzed.

A. Well, diabetics are a subgroup.

Q. Just a moment. Doctor, just a moment. Let me ask you a question. My question was not limited to whether diabetics were subgroup analyzed in the Cochrane study.

My question was: There is some evidence, in fact, that pneumococcal vaccine is protective in diabetics, because diabetics were included in the Cochrane study?

A. I disagree with that. Just because diabetics were included in the Cochrane study doesn't mean that they, as a specific risk group, were specifically protected. There is no evidence for that.

That's like saying there were women in the Cochrane study; and therefore, women were specifically protected. The analysis wasn't done in that manner.

Q. But women are specifically protected by the pneumococcal vaccine, right?

A. No, they're not.

Q. Even though probably half the --

A. In that --
Q. Just a moment.
A. In that Cochrane analysis --
Q. Just a minute, Dr. Young.
A. -- they're not protected. They weren't -- there was not a specific analysis by sex.
Q. Okay. I think we understand your point. I want to address a couple of issues that counsel talked to you about concerning your history. I believe you and I went over these a little bit.

The last pneumococcal study that you were involved in was in 1979, correct?
A. Correct.
Q. Pneumococcal infections after bone marrow transplantation?
A. Correct.
Q. You would agree since 1979, which would have been 34 years ago, there have been quite a few advances in the treatment of infectious disease?
A. I agree with that.
Q. And even in the last 13 years there have been many -- during the time you haven't been a practicing infectious disease physician, there have been many advances in the treatment of infectious disease, even invasive pneumococcal disease?

A. Well, there certainly have been advances, but as far as the vaccine is concerned, the polysaccharide vaccine is the same one as from the 1970s.

Q. The polysaccharide vaccine that is the one that's PPV-23, the CDC determined that that was to be given to diabetics in 1997, right?

A. I believe that's the recommendation, yes.

Q. So in 1997, as an infectious disease physician, you would have given the pneumococcal vaccine to your diabetic patients?

A. Yes.

MS. CURTIS: Your Honor, at this time I would cease questioning Dr. Young, although I do have some additional argument.

THE COURT: I've got a couple questions here, Doctor. Just give me a moment here.

During your practice and at any time you may have been training or educating students, did that include training involving patients who had both diabetes and pneumonia?

THE WITNESS: Yes.

THE COURT: And the same question with respect to your training. Did that ever involve patients who had both diabetes and pneumococcal meningitis?

THE WITNESS: Yes.

THE COURT: All right. Those are my two questions. In light of those, are there any follow-up questions from either attorney?

MS. RETTS: No, Your Honor.

THE COURT: Ms. Retts? All right. Ms. Curtis, anything further?

MS. CURTIS: I just have one question, Your Honor.

THE COURT: That's fine.

FURTHER EXAMINATION

BY MS. CURTIS:

Q. So, Dr. Young, just a moment ago I asked you whether you gave patients, 13 years ago, the pneumococcal vaccine.

A. I'm sorry. Could you just speak up a little bit louder?

Q. Dr. Young, you do have a slight hearing issue, don't you? I'd forgotten.

A. Well, I can just hear you now, but if you could repeat the question.

Q. Yes, sir. A few minutes ago I asked you whether you gave the pneumococcal vaccine to diabetics when you were in practice.

A. The answer is "Yes."

Q. All right. I just wanted to make sure that I

understood.

MS. CURTIS: Thank you.

THE COURT: I have one other question.

Would you describe for me what you have been doing in the last 13 or so years with respect to the work that you do?

It wasn't clear to me whether the work that you're doing now you believe in any way relates to your having considered this particular case and made the recommendations and the opinions that you have given.

THE WITNESS: Right. Well, the work that I've been doing in the laboratory has been with a germ called mycobacterium avium complex. It occupied approximately 50 percent of my time and was entirely supported by the National Institutes of Health, part of the AIDS treatment program.

And then the remaining of the time, 40 percent, I was editor of a journal called Antimicrobial Agents and Chemotherapy, which is the world's leading journal in the field of antibiotics.

The remaining 10 percent of my time I spent on hospital committees.

THE COURT: Okay. Anything further, counsel, of Dr. Young?

MS. CURTIS: No, thank you.

THE COURT: Ms. Retts?

MS. RETTS: No.

THE COURT: Doctor, I will excuse you at this time. Thank you very much.

THE WITNESS: Thank you. Goodbye.

THE COURT: All right. Goodbye.

THE WITNESS: Goodbye.

THE COURT: Have a good day.

THE WITNESS: You, too.

(The witness' phone was disconnected.)

THE COURT: Okay. We have that humming noise there.

(A discussion was held off the record between the Court and Courtroom Deputy Carol Bevel.)

THE COURT: All right. Counsel?

MS. CURTIS: Yes, Your Honor.

THE COURT: Go ahead, Ms. Curtis.

MS. CURTIS: Your Honor, quickly, I just wanted to finally address that the questioning of Dr. Young is evidence of the reason why we made the challenge to begin with.

He wants a level of proof that does not exist, and cannot be met, and is not an appropriate level for causation opinion.

He admitted that the CDC, the ACIP, all require that there be vaccination of diabetics. He said that the case controlled studies, like the Cochrane study, which is the basis for Dr. Martin's opinion, is a reasonable basis for public health decisions on vaccination and clinical medicine.

And, finally, he said that he, himself, when he was in clinical practice 13 years ago, vaccinated diabetics with the pneumococcal vaccine.

These are all reasonable things to do, and they would be reasonable cross-examination questions if I had a bunch of medical researchers sitting on the jury, but I'm not going to. I'm going to have a bunch of lay people that won't understand the difference between what he is saying about specific studies being honed in on a very, very specific population.

You heard Dr. Young testify that he doesn't believe the Cochrane study proves that women should be vaccinated with pneumococcal vaccine, although it had 18,000 people, which he understands includes women. All right?

This need for tremendous specificity, which is not needed by any public health organization in the world, is unreasonable. And it's misleading, is my biggest concern about that testimony, is that juries are easily

misled by a very strong opinion by someone who is not following our burden requirements.

And so this is my issue with his testimony.

It's not that he's not a very qualified medical researcher. It's that his testimony -- his not being in the field for 13 years means he has no personal experience with it. And two, that he is requiring a different level of research.

Also, he literally disavowed his own two bases, medical bases for his testimony, which is the Simberkoff and the Ortquist articles, saying that they only dealt with pneumonia, not invasive pneumococcal disease.

So it's the misleading nature of his emphatic testimony that I don't believe.

And the reason that we have Daubert hearings like this is that the Court can analyze these very intricate research issues much better than a lay jury.

And so it's that emphatic refusal to take what evidence exists for everyone else that makes vaccination decisions, including himself, in the clinical setting, and transfer those to a causation opinion.

And so it's the misleading nature of the testimony is the reason for the Daubert motion, Your Honor.

THE COURT: All right.

MS. CURTIS: Thank you.

THE COURT: Counsel?

MS. RETTS: Your Honor, I think it's important to note this continued blurring between the standard of care and causation.

We have cases all across this country that deal with drugs in a medical arena, where the treating physician's opinion relative to the standard of care may be different than the underlying causation and data and evidence relative to drug efficacy.

Certainly public health decisions are not necessarily made upon the same standard of causation that's required for proof in this case.

This also brings up this important issue about the serotype which plaintiff continues to believe is irrelevant in this case. But all of the studies that we're talking about still deal only with serotypes included in the vaccine.

So this is another issue here, and Dr. Young needs to be able to explain that there simply is no data of any sort. There's no randomized clinical trial, and the reliance upon a randomized clinical trial is not Dr. Young's; it's plaintiff's counsel's questioning and focusing in solely on that, in directing him back solely to that, to the exclusion of the other basis for that opinion,

which is, in his report he cited to medical literature, he cited to research articles.

And the fact that different medical experts come to different conclusions based upon research, when the research has specific limitations in it, goes to the weight of the evidence, not the admissibility.

Certainly there are letters after the Cochrane study, indicating challenges to its analysis. And as Dr. Young pointed out, those specific subgroups have not been studied in any type of retroactive cohort study, any type of analysis other than even the randomized clinical trial.

And I think it's really important to note that distinction, because it creates the problem of confusing the jury in the other sense, of saying, just because there is a policy on this, that causation is necessarily proven.

Those two things are not mutually exclusive. And the example I would give of that is the CDC's recent recommendation relative to hepatitis testing, hepatitis C in particular, recommending that adults over the age of, I believe it's 55, all be tested for hepatitis C.

Well, we certainly all know that hepatitis C is based upon, usually, some risky form of behavior, risky sexual behavior, risky drug-using behavior. Certainly it's

not believed that the whole population of folks over 55 has engaged in that type of behavior, such that the standard of care is that they are all tested regardless of their underlying risk factors.

But that illustrates, I think, nicely this idea that a public health policy is necessarily over-protective. It's necessarily maybe broader than the underlying data that would support causation.

And that can get confusing, which is why Dr. Young's testimony is necessary to explain the scientific analysis for the disease process, explain the meningitis, how it differs from pneumonia, but how it is actually most commonly based on pneumonia, and you need that blood-brain barrier jump to explain all these facets that play into this case, other than just a blanket policy or a recommendation, which we know from the course of medical practice, those things change over time.

And they change over time because of medical research that's been done or data that exists to support things.

THE COURT: Is it relevant at all to that last series of remarks, that he has not been doing the same work that he had been doing for the last 13 or so years?

MS. RETTS: The underlying pneumococcal bacteria has not changed. The bacteria is the bacteria. So

when Dr. Young was treating patients, the pneumococcal bacteria caused meningitis in the same way that it does today.

THE COURT: Right. But in terms of his involvement in any recent research?

MS. RETTS: Dr. Young has done --

THE COURT: He's doing something very different now than he was doing 13 years ago.

MS. RETTS: But specific to the research that he does, what I think is important in that, as a medical researcher, he has the expertise to be able to look at research studies and critically analyze them.

THE COURT: I tried to elicit that from him. That's why I asked those two questions at the end. And he didn't say very much.

MS. RETTS: Yeah.

THE COURT: And nobody followed up on it.

MS. RETTS: I believe that that's in his deposition testimony, which I thought was attached to the Daubert motion.

THE COURT: It is. Yes.

MS. RETTS: Was the fact that, you know, as part of a researcher's job, he is developing these studies. He's going through and looking very scientifically at these types of things.

So that's an underlying skill set that he has that's different from just a clinical practitioner, to go through and take a look at research that's been done and make conclusions about that research.

THE COURT: Okay. I understand. All right.

Ms. Curtis, anything further?

MS. CURTIS: If I could just -- I just wanted to say one thing, because it was raised, Your Honor, if I may?

I do have a new cuss word in my repertoire. It's called "serotype." That word just sends fits.

Dr. Young said absolutely not a single word about serotype, Your Honor. And if you'll notice in the exhibits, at Page 59 --

THE COURT: Okay. Hold on. Hold on. Let me look it up here. All right. Go ahead.

MS. CURTIS: I asked: "I asked you whether you've been engaged by the defendants to give an expert opinion at trial in this case regarding serotypes."

THE COURT: Page 59, you said?

MS. CURTIS: I'm sorry. It's Page 61 of the deposition.

THE COURT: All right.

MS. CURTIS: Which, of course, is four to a page, so 61 is that last page on the right.

THE COURT: Okay. Hold on.

MS. CURTIS: You bet.

THE COURT: Talking about Dr. Young's deposition?

MS. CURTIS: Yes, Your Honor.

THE COURT: And it's Page 61?

MS. CURTIS: Yes.

THE COURT: And we're talking about the exhibit that's attached to the defendants' response?

MS. CURTIS: Your Honor, I have an actual copy of the deposition.

THE COURT: Because I'm not looking -- I don't see a 61 on the attachment.

MS. CURTIS: You know, it may be in the serotype motion in limine.

THE COURT: Okay. Go ahead and put it on the ELMO if you want.

MS. CURTIS: Yes, yes, yes. That's a great idea.

THE COURT: It's not in the motion. All right. And you can make it smaller with the push of a button on there. All right.

MS. CURTIS: "I asked you whether you've been engaged by the defendants to give an expert opinion at trial in this case regarding serotypes."

"THE WITNESS: The answer is that's never come up in this case."

And I said: "Okay, that's fine. I -- just an area I needed to ask you whether that's an issue or not. But I didn't see anything in your report concerning serotypes."

I said: "That's correct, right?"

And he said: "That's correct."

Then here at Line 12 --

THE COURT: Just go ahead and move it over there. There we go.

MS. CURTIS: Line 12: "So I just want to know that you're not going to testify about serotypes for invasive pneumococcal disease in New Mexico."

"ANSWER: I have no information on that, if that's your question."

All right. So Dr. Young -- I'm not sure why defense counsel raised the serotype issue. I just wanted to make sure that we are very clear, because I didn't ask any of those questions of him. That's not an area of testimony for Dr. Young.

THE COURT: All right. Anything further? Anything, Ms. Retts?

MS. RETTS: Your Honor, I would just address that Ms. Curtis did raise the serotype issue with Dr. Young in her questioning of him, which is why I brought it up. And his testimony was that we don't know the serotype, which a

lot of those serotype issues are actually affirmatively established through the request for admissions.

THE COURT: Okay. Ms. Retts had indicated that there was, in her remarks here, which she termed, if I have it correctly here, a blurring of or between the standard of care and causation.

What would be your response to that, Ms. Curtis?

MS. CURTIS: Yes. When I heard that argument, I don't believe there's any blurring between the standard of care and causation.

I'm talking about the burden of proof. The burden of proof for causation is that it is more likely than not that the failure to give pneumococcal vaccine was the cause of Jose Jaramillo's invasive pneumococcal disease.

That's what I'm talking about. I'm not blurring the standard of care.

Obviously, the issue is relevant, that Dr. Young is testifying that he doesn't believe that there's sufficient medical research to support the causation opinion that pneumococcal vaccine would stop invasive pneumococcal disease in a diabetic.

However, he chose to do it. He chose to do it to his own patients, although today in court he's testifying that there's no reason to believe that it would have any

effect.

I mean, so from that perspective, that's not a standard of care issue. That's literally just an impeachment issue. If you don't believe that there's any effect, why would you give it to your patients?

So the protective effect issue is merely for impeachment.

But no, my whole issue is about burden of proof and causation. Causation cannot be proven, Your Honor, by the standard that is required by Dr. Young. That is an undue standard of care.

He just won't -- he will not cite to the resources that show this is an effective vaccine. He just denies that and requires a level of proof that is unreasonable and does not exist.

So that's why standard of care and causation are not blurred.

THE COURT: Okay. All right. Is there anything further, then, on this motion here before we talk about scheduling?

MS. CURTIS: No, Your Honor.

MS. RETTS: No, Your Honor.

THE COURT: Okay. And I take it there's nothing the parties wish me to consider, other than, obviously, the deposition testimony that's attached?

We don't have any reports or anything like we did this morning?

MS. CURTIS: I don't believe so, Your Honor.

THE COURT: All right. That's what I need to know.

The matter is under advisement.

Let's talk about scheduling. Do you want this on the record? I don't think that we need to be on the record for this. Julie, we'll conclude this hearing, and we are off the record.

(Proceedings concluded at 3:10 p.m.)

UNITED STATES OF AMERICA

DISTRICT OF NEW MEXICO

CERTIFICATE OF OFFICIAL REPORTER

I, Julie Goehl, RDR, CRR, RPR, RMR, New Mexico CCR #95, Federal Official Realtime Court Reporter, in and for the United States District Court for the District of New Mexico, do hereby certify that pursuant to Section 753, Title 28, United States Code, that the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 21st day of March, 2014.

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